

Steven M. Van Scoyoc, D.D.S., M.S., P.A.

Practice Limited to Periodontics & Implants

PATIENT INFORMATION

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and considered confidential.

Personal Information:

Last Name First MI Nickname Date
Home Address: _____ Home Phone:(_____)_____
City: _____ State: _____ Zip Code: _____ Cell Phone:(_____)_____
Employer: _____ Work Address: _____
City: _____ State: _____ Zip Code: _____ Work Phone:(_____)_____
Sex: M F Marital Status: S M D W Social Security #: _____
Birthday: _____ Referring Dentist: _____ E-mail: _____
Person Responsible for Payment of Account (if other than self): _____
Address: _____ Relationship to Patient: _____
City: _____ State: _____ Zip Code: _____ Phone Number:(_____)_____

Emergency Contact Information:

Name: _____ Home Phone:(_____)_____
Relationship to Patient: _____ Work Phone:(_____)_____

Dental Insurance Information: (if applicable)

Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's Social Security #: _____ Subscriber's DOB: _____
Subscriber's Employer: _____ Insurance Company: _____
Insurance Claims Address: _____ Group #: _____
City: _____ State: _____ Zip Code: _____ Phone Number:(_____)_____

Medical/Dental History:

Medical Physician's Name: _____ Phone Number:(_____)_____
Reason for Last Visit: _____ Date of Last Visit: _____

Have you ever experienced or been diagnosed with:

YES <input type="checkbox"/> NO <input type="checkbox"/> AIDS/HIV	YES <input type="checkbox"/> NO <input type="checkbox"/> Bladder Troubles
YES <input type="checkbox"/> NO <input type="checkbox"/> Abnormal Bleeding	YES <input type="checkbox"/> NO <input type="checkbox"/> Blood Disease
YES <input type="checkbox"/> NO <input type="checkbox"/> Anaphylaxis	YES <input type="checkbox"/> NO <input type="checkbox"/> Cancer
YES <input type="checkbox"/> NO <input type="checkbox"/> Anemia (Sickle Cell Anemia)	YES <input type="checkbox"/> NO <input type="checkbox"/> Chest Pain
YES <input type="checkbox"/> NO <input type="checkbox"/> Arthritis	YES <input type="checkbox"/> NO <input type="checkbox"/> Circulatory Problems
YES <input type="checkbox"/> NO <input type="checkbox"/> Artificial Heart Valves	YES <input type="checkbox"/> NO <input type="checkbox"/> Cold Sores, Blisters
YES <input type="checkbox"/> NO <input type="checkbox"/> Artificial Joints	YES <input type="checkbox"/> NO <input type="checkbox"/> Congenital Heart Failure
YES <input type="checkbox"/> NO <input type="checkbox"/> Asthma	YES <input type="checkbox"/> NO <input type="checkbox"/> Cortisone Treatments
YES <input type="checkbox"/> NO <input type="checkbox"/> Back Problems	YES <input type="checkbox"/> NO <input type="checkbox"/> Cough, persistent or bloody
YES <input type="checkbox"/> NO <input type="checkbox"/> Bisphosphonates Treatment	YES <input type="checkbox"/> NO <input type="checkbox"/> Diabetes, Type: _____
	YES <input type="checkbox"/> NO <input type="checkbox"/> Drug or Alcohol Addiction

- | | | | | | |
|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|------------------------------|
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Emphysema | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Radiation Treatment |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Epilepsy | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Respiratory Disease |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Fainting/Dizziness | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Rheumatic/Scarlet Fever |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Glaucoma | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Sexually Transmitted Disease |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Headaches | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Shortness of Breath |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Heart Murmur: | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Sinus Trouble |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Heart Problems | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Skin Rash |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Hemophilia | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Spinal Bifida |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Hepatitis, Type:_____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Stroke |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Herpes | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Swollen Feet or Ankles |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | High/Low Blood Pressure | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Swollen Neck Glands |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Jaw Pain | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Thyroid Problems |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Kidney Disease | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Tonsillitis |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Liver Disease | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Tuberculosis |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Mitral Valve Prolapse | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Tumor/Growth on head or neck |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Pacemaker | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Ulcers |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Pre-medicate with antibiotics | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Weight Loss, unexplained |
| YES <input type="checkbox"/> | NO <input type="checkbox"/> | Psychiatric Care | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Other:_____ |

YES NO Do you have any known ALLERGIES at the present time? If yes, please list:_____

YES NO Are you being treated by a medical doctor now? If yes, why?_____

YES NO Are you taking any MEDICATION at the present time? If yes, please list:_____

YES NO Have you ever had any surgical operations or ever been hospitalized? If yes, please list reasons and dates:_____

YES NO Have you ever had complications from oral surgery or IV sedation? If yes, please explain:_____

YES NO Have you had any serious trouble associated with any previous dental treatment? If yes, please explain:_____

YES NO Have you recently had dental x-rays? When?_____ Which office?_____

YES NO Do you clench or grind your teeth? If so, do you wear a bite guard? _____

YES NO Are any of your teeth sensitive to cold or sweets?

YES NO Have you had excessive swelling, pain, or excessive bleeding after oral surgery?

YES NO Do you have your teeth cleaned on a regular basis? If yes, how often: every_____

YES NO Do you have bleeding gums?

YES NO Have you ever received treatment for periodontal disease?

YES NO Have you ever used tobacco? If yes, **what type** and **how much** per day?_____

YES NO Have you ever quit? If so, when? _____

YES NO If you answered yes to the previous question, are you interested in tobacco counseling?

YES NO Do you wish to talk to the doctor privately about any problem?

For Females Only:

YES NO Are you pregnant? If yes, what is your due date?_____

YES NO Are you nursing?

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE ANSWERS ARE TRUE AND CORRECT. IF I HAVE ANY CHANGE IN MY HEALTH; I WILL INFORM DR. VAN SCOYOC BY MY NEXT APPOINTMENT.

Patient's Signature

Date