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

YES ☐ NO ☐ Emphysema
YES ☐ NO ☐ Epilepsy
YES ☐ NO ☐ Fainting/Dizziness
YES ☐ NO ☐ Glaucoma
YES ☐ NO ☐ Headaches
YES ☐ NO ☐ Heart Murmur:
YES ☐ NO ☐ Heart Problems
YES ☐ NO ☐ Hemophilia
YES ☐ NO ☐ Hepatitis, Type:_____
YES ☐ NO ☐ Herpes
YES ☐ NO ☐ High/Low Blood Pressure
YES ☐ NO ☐ Jaw Pain
YES ☐ NO ☐ Kidney Disease
YES ☐ NO ☐ Liver Disease
YES ☐ NO ☐ Mitral Valve Prolapse
YES ☐ NO ☐ Pacemaker
YES ☐ NO ☐ Pre-medicate with antibiotics
YES ☐ NO ☐ Psychiatric Care

YES ☐ NO ☐ Radiation Treatment
YES ☐ NO ☐ Respiratory Disease
YES ☐ NO ☐ Rheumatic/Scarlet Fever
YES ☐ NO ☐ Sexually Transmitted Disease
YES ☐ NO ☐ Shortness of Breath
YES ☐ NO ☐ Sinus Trouble
YES ☐ NO ☐ Skin Rash
YES ☐ NO ☐ Spinal Bifida
YES ☐ NO ☐ Stroke
YES ☐ NO ☐ Swollen Feet or Ankles
YES ☐ NO ☐ Swollen Neck Glands
YES ☐ NO ☐ Thyroid Problems
YES ☐ NO ☐ Tonsillitis
YES ☐ NO ☐ Tuberculosis
YES ☐ NO ☐ Tumor/Growth on head or neck
YES ☐ NO ☐ Ulcers
YES ☐ NO ☐ Weight Loss, unexplained
YES ☐ NO ☐ 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**