C.I.P.
Central Indiana Periodontics P.C.
Practice Limited to Periodontics and Implantology

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Today's Date: ___________________________

Name: Dr. Mr. Mrs. Miss ____________________/____ / _____________________________ Date of Birth:____________________________
FIRST NAME M.I. LAST NAME

Social Security # ____ Marital Status: ❏ Single ❏ Married ❏ Divorced ❏ Widowed

Spouse's name or name of parent/guardian (if patient is a minor):__________________________________ _____________________________________

Home Address: ____ Home Phone: (_______) ________________________

City: ___________________________________ State: _______ Zip:________________ Business Phone: (_______) ________________________

Email:____ Cell Phone: (_______) ________________________

Place of Employment: ____ Occupation:______________________________________
FIRST NAME LAST NAME

Family Dentist's Name: _________________________________ _______________________________ How long?________________________________
FIRST NAME LAST NAME

Physician's Name:_____________________________________ _______________________________ How long?________________________________

MEDICAL HISTORY

Please answer the following accurately and completely. The diagnosis and treatment of your condition depends upon the identification of every possible contributing factor. Though some of the questions seem unrelated to your periodontal condition, they are all associated with proper management of your oral health.

	YES	NO
Have you ever had any serious illnesses or operations?	❏	❏

If yes, please explain____

Date of your last physical examination ____

	YES	NO
Are you now under the care of a physician?	❏	❏

If yes, for what? ____

	YES	NO
Are you presently taking any drugs or medications?	❏	❏

List____

____

Have you had any of the following conditions?

- ❏ Heart disease
- ❏ Heart murmur
- ❏ Mitral valve prolapse
- ❏ High blood pressure
- ❏ Low blood pressure
- ❏ Excessive bleeding
- ❏ Circulatory problems
- ❏ Anemia
- ❏ Stroke
- ❏ Rheumatic fever
- ❏ Osteoporosis
- ❏ Epilepsy
- ❏ Asthma
- ❏ Tuberculosis or lung disease
- ❏ Allergies
- ❏ Sinus problems
- ❏ Diabetes
- ❏ Ulcer
- ❏ Cancer
- ❏ HIV + / AIDS
- ❏ Venereal disease
- ❏ Hepatitis
- ❏ Thyroid condition
- ❏ Arthritis

Are you allergic to or unable to take any of the following drugs?

- ❏ Local anesthesia ("Novocaine")
- ❏ Codeine
- ❏ Penicillin
- ❏ Other antibiotics (please list) ______________________________________
- ❏ NSAID's
- ❏ Latex
- ❏ Aspirin
- ❏ Other

	YES	NO
Have you ever taken anti-coagulants (blood thinner)?	❑	❑
Do you have any artificial implants (hip, knee, heart valve)?	❑	❑
Have you ever had any abnormal bleeding following dental extractions, surgery or a cut?	❑	❑
Have you ever had radiation treatment for a tumor or skin disease?	❑	❑
Has any blood relative ever had diabetes?	❑	❑
Do you get pain in your chest or over your heart?	❑	❑
Have you been exposed to hepatitis, HIV or any sexually transmitted diseases?	❑	❑
Have you ever taken the medication Fosomax or another Bisphosphonate?	❑	❑
Have you had cortisone within the past year?	❑	❑

Do you smoke? ❑ YES ❑ NO If yes, how much? ______________________________

Do you drink alcohol? ❑ YES ❑ NO If yes, how much? ______________________________

FOR WOMEN ONLY	YES	NO
Are you pregnant?	❑	❑
Are you using birth control?	❑	❑
Have you reached menopause?	❑	❑
Are you taking hormones?	❑	❑

DENTAL HISTORY	YES	NO
What is your dental concern? ______________________________		
Are you having any discomfort or pain?	❑	❑
If so where? ______________________________		
Are your teeth sensitive to cold, hot or sweets?	❑	❑
Do you clench or grind your teeth?	❑	❑
Do your jaws ache when you awaken in the morning?	❑	❑
Have you noticed any loose or shifting teeth?	❑	❑
Do you feel that you chew satisfactorily?	❑	❑
Are you satisfied with the appearance of your teeth?	❑	❑
Have you had orthodontic therapy (braces)?	❑	❑
Do your gums bleed?	❑	❑
Do you get pain in your chest or over your heart?	❑	❑
Have you noticed a mouth odor or bad taste?	❑	❑
Do you ever have fever blisters or cold sores on your lips?	❑	❑
Have you had previous gum treatment or periodontal therapy?	❑	❑
If yes with what dentist? ____________________ When? ____________________		
Would you be upset if you had to lose your teeth and wear false teeth?	❑	❑
Have we treated any of your family or friends?	❑	❑
If so, who? ______________________________		

Signature: ______________________________ Date: ______________________________

DENTAL INSURANCE INFORMATION

Main Guarantor: ______________________________

ID# ______________________________ Date of Birth: ______________________________

Insurance Company: ______________________________

Group # ______________________________ Place of employment: ______________________________