PERIODONTAL SERVICES, LTD.
ARNOLD L. FREEDMAN, D.D.S.
JONATHAN S. FRIEDMAN, D.M.D.
PRACTICE LIMITED TO PERIODONTICS

PATIENT HEALTH RECORD

Please Print

REFERRED BY _____

DATE _____ DENTIST'S PHONE _____

NAME _____ AGE _____ BIRTH DATE _____

SEX _____ MARITAL STATUS _____ SOCIAL SECURITY NO. _____ HOME PHONE _____

HOME ADDRESS _____ CELL PHONE _____
Street City State Zip

EMAIL _____

EMERGENCY CONTACT INFO: _____
Name Relationship Phone Number(s)

PLACE OF EMPLOYMENT _____ OCCUPATION _____

ADDRESS _____ PHONE _____
Street City State Zip

DO YOU HAVE DENTAL INSURANCE ___ YES/NO ____ COMPANY _____

POLICY NO. _____ GROUP/AGREEMENT NO. _____

IF SPOUSE/PARENT ALSO HAS INSURANCE - COMPLETE THE NEXT SECTION. (PARENT PLEASE COMPLETE IF PATIENT IS A MINOR)

SPOUSE/PARENT NAME: _____ SOCIAL SECURITY NO. _____

PLACE OF EMPLOYMENT _____ DATE OF BIRTH _____

DOES SPOUSE/PARENT HAVE DENTAL INS.: ___Y ___N INS. CO. _____

POLICY NO. _____ GROUP/AGREEMENT NO. _____

MEDICAL HISTORY

Check the Appropriate Answer. If You Don't Know the Correct Answer, Please Write "Don't Know" After the Question.

	YES	NO
1. Are you taking any medication now?	❑	❑
Please list your medications: _____		
2. Do you have any allergies or sensitivities?	❑	❑
Please list: _____		
3. Have you ever been hospitalized?	❑	❑
For what? _____		

4. Have you ever been treated for:

	YES	NO		YES	NO
AIDS/HIV Disease	❑	❑	Liver Disease, Hepatitis, Jaundice	❑	❑
Heart Disease/Stroke	❑	❑	Blood Disorder/Anemia	❑	❑
Rheumatic Fever/Heart Valve Problems	❑	❑	Venereal Disease	❑	❑
Pacemaker	❑	❑	Glaucoma	❑	❑
High Blood Pressure	❑	❑	Tumors or Growths/Cancer	❑	❑
Ulcers	❑	❑	Auto Immune Disease	❑	❑
Diabetes	❑	❑	Asthma or Emphysema	❑	❑
Epilepsy	❑	❑	Sinus Trouble	❑	❑
Mental Problems or nervous disorders	❑	❑	Artificial Joint Replacement/Prosthesis	❑	❑
Kidney Trouble	❑	❑	Other _____	❑	❑
Osteoporosis/Osteopenia	❑	❑			

5. Do you often have spells of dizziness or fainting?	❑	❑
6. (Women) Are you pregnant?	❑	❑
7. Are you in good health at this time?	❑	❑
8. Do you smoke, chew tobacco, or have any other oral habits?	❑	❑

PHYSICIAN _____ PHONE _____
Name Address

I consent to treatment as necessary or desirable. I also acknowledge full responsibility for payment for such treatment.

Signature: _____ Date: _____
Patient, Parent or Guardian (must be 18 years or older)

Reviewed By: _____

PLEASE TURN OVER AND COMPLETE SECOND SIDE OF THIS FORM

DENTAL HISTORY

CHECK THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "Don't Know" AFTER THE QUESTION.

	YES	NO
1. Are you presently in pain?	❑	❑
2. Purpose of this initial visit		
3. How long since your last dental visit?		
4. What was done at that time?		
5. When was the last time you had your teeth cleaned?		
6. Have you been told to premedicate prior to dental visits? ..... For what purpose?		
7. What antibiotics do you take?		
8. Do you make regular visits to your dentist?	❑	❑
How often?		
9. Were dental x-rays taken?	❑	❑
10. Have you lost any teeth, or have any teeth been removed?	❑	❑
Why?		
How have they been replaced?		
Fixed bridge	❑	❑
Removable bridge	❑	❑
Denture	❑	❑
11. Are you satisfied with the replacements?	❑	❑
12. Would you like to know about permanent replacements/Dental Implants?	❑	❑
13. Have you ever had any problems or complications with previous dental treatments?	❑	❑
If yes, explain:		
14. Do you clench or grind your teeth?	❑	❑
15. Does your jaw click or pop?	❑	❑
16. Do you experience any pain or soreness in the muscles of your face or around your ear?	❑	❑
17. Do you have frequent headaches, neck aches, or shoulder aches?	❑	❑
18. Does food get caught in your teeth?	❑	❑
19. Are any of your teeth sensitive to: ❑ Hot? ❑ Cold? ❑ Sweets? ❑ Pressure?	❑	❑
20. Have you ever had a severe bleeding problem after an extraction?	❑	❑
21. Do your gums bleed when you brush your teeth?	❑	❑
22. Are your teeth loose, tipped, shifted or chipped?	❑	❑
23. Are you unhappy with the appearance of your teeth?	❑	❑
24. How do you feel about your teeth in general?		
25. Do you feel your breath is offensive?	❑	❑
26. Have you ever had gum treatment or surgery? ..... What? ..... When?	❑	❑
Where?		
27. Have you ever had any orthodontic work?	❑	❑
28. Have you had unpleasant dental experiences? ..... Explain:	❑	❑
29. Are there any other concerns that you would like to discuss?		

I consent to treatment as necessary or desirable. I also acknowledge full responsibility for payment for such treatment.

Signed: _____

Patient, Parent or Guardian (must be 18 years or older)

Reviewed By: _____