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BROWARD CENTER FOR PERIODONTICS, IMPLANTS & LASER TREATMENTS

WELCOME

TODAYS DATE: _____

Single Married Divorced Widowed Separated

About You

Male Female

Name: _____
Last First MI (Mr. Ms. Mrs. Dr.)

Home #: _____ Cell# _____ Work# _____

Birthdate: _____ Age: _____ Social Sec#: _____

Home Address: _____

Email: _____

Employer: _____

Phone #: _____

Current Dentist: _____ PH: _____

Whom May We Thank for Referring You? _____

Person Responsible for Account

Name: _____

Address: _____

Relationship: _____

Phone: _____

Spouse Information

Name: _____

Home#: _____ Cell: _____

Employer: _____

Work#: _____

Birthday: _____

Dental Insurance

Insured's Name: _____

Relation: _____

Insurance Co. Name: _____

Insurance Co. PH#: _____

Group Policy# _____ Group# _____

Insured's Social Sec#: _____

Insured's Birthday: _____

Insured's ID: _____

What is your primary concern about your mouth?

Do you smoke? Yes/ No

Are you currently in pain? Yes / No

Do you now or have you ever experienced pain/discomfort
in your jaw Joint (TMJ)? Yes/ No

Do your gums bleed? Yes/ No

Do you have a water pik? Yes/ No Do you use it? Yes/ No

Have you ever been examined specifically for periodontal disease?
If yes by whom? Dr. _____

Do you frequently eat sweets, use mints, or gum? Yes/No

How severe do you consider your gum problem?

Minimal Moderate Severe

Does the appearance of your teeth bother you? Yes/ No

Have you ever had a serious or difficult problem associated with any
previous dental work? Yes/No If yes, what did you have done?

Do you use anything to clean between your teeth?
Yes/ No If yes, what? _____

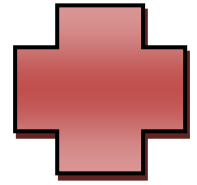
When were your teeth last cleaned by a dentist? _____

Are you nervous about dental visits? Yes/No

Are you bothered by persistent bad breathe or bad taste in your mouth?
Yes/ No

What other information would help us serve you better?

MEDICAL HISTORY



How would you describe your health?

Excellent Good Fair Poor

Have you ever been hospitalized?

Yes/No If yes, what for?

Are you currently under the care of a Physician? Yes/No

Pharmacy #: _____

If yes, please explain: _____

Do you need to Pre-Med before dental visits? Y/N

Physician's Name: _____

If yes, what for? _____

Work #: _____

What medication do you take? _____

Please list any medications that you are taking Including *ASPIRIN & PLAVIX*:

Are you Allergic to any of the following drugs?

Are you taking birth control pills? Yes/No

Y/N Penicillin Y/N Codeine Y/N Erythromycin
Y/N Tetracycline Y/N Aspirin Y/N Latex
Y/N Barbituates Y/N Sleeping Pills Y/N Dental Anesthetics
Y/N Sedatives Other Allergies: _____

Are you pregnant? Yes/No

Have you ever had any of the following? Please check and circle: ←

- | | |
|---|---|
| <input type="checkbox"/> Heart Attack / Stroke | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Anemia/Radiation Treatment |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Surgery/Pacemaker |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Epilepsy/Seizure/Fainting Spells |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Asthma/Arthritis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Artificial Bones/Joints |
| <input type="checkbox"/> Diabetes/Tuberculosis (TB) | <input type="checkbox"/> Artificial Valves/Stent |
| <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Sinus Problems/Allergies |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> High/low Blood Pressure |
| <input type="checkbox"/> Hemophilia/Abnormal Bleeding | <input type="checkbox"/> Fever Blisters/Shingles |
| <input type="checkbox"/> Osteoporosis/Meds for? | <input type="checkbox"/> Severe/Frequent Headaches |
| <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Ephysema/Glaucoma |

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

→ Signature _____

→ Date: _____

OFFICE USE ONLY Medical History Update

I VERBALLY REVIEWED THE MEDICAL/ DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN: Initials _____ Date _____

1. Date _____ Comments _____ Signature _____
2. Date _____ Comments _____ Signature _____
3. Date _____ Comments _____ Signature _____