

David Goteiner, DDS, LLC

Practice limited to periodontics Spec #2218 • Oral medicine • Dental implants

IN ORDER TO HELP RENDER THE PROPER DENTAL SERVICES TO YOU, PLEASE BE KIND ENOUGH TO ANSWER THE FOLLOWING QUESTIONS PLEASE NOTE THERE IS ROOM FOR CLARIFICATION AND ANY OTHER INFORMATION YOU THINK WE SHOULD HAVE. THANK YOU FOR YOUR COOPERATION.

Name _____ Date of Birth _____
Address _____ City _____ Zip code _____
Home Phone _____ Work Phone _____ Cell Phone _____
In case of emergency, whom should we contact? _____ Phone# _____
Dentist _____ Physician _____ Date of Last Visit to MD _____
Employer _____ Social Security No. _____
Dental Insurance _____ SS# of the Insured _____
Insured's Name _____ Insured's Date of Birth _____
Insurance ID# _____ Do you have secondary insurance? **Yes** **No**

MAY WE LEAVE MESSAGES ON YOUR HOME PHONE? **Yes** **No**

MAY WE CONTACT YOU BY EMAIL? _____ @ _____

MEDICAL HEALTH

If you are taking medications, herbs or supplements now, please tell us which ones and why. _____

Do you have allergies? ___ To what? _____

Have you ever had an operation, radiation or chemotherapy? _____

Have you ever been hospitalized and why? _____

Have you ever been seriously ill? _____

Do you have osteoporosis? _____ If yes what medication are you taking? _____

Yes **Do you have asthma, sleeping problems? Sleep Apnea or trouble sleeping?** **No**

Yes **Do you have any artificial joints?** **No** **Do you have problems with the joint?** _____

Yes **Do you have heart problems?** **No** **pacemaker** **No**

Yes **Has a physician requested antibiotic coverage (Premedication) before dental visits?** **No**

Yes **Do you have anemia?** **No**

Yes **Do you have high or low blood pressure?** **No**

Yes **Do you have numbness, tingling or swelling anywhere?** **No**

Yes **Do you have arthritis?** **No** **Where?** _____

Yes **No** **Do have diabetes? How are you treating it?** _____

Do you have fainting spells, seizures, or recurrent headaches? _____ **Yes** **No**

Have you ever had liver trouble, hepatitis, or jaundice? _____ **Yes** **No**

Have you ever been treated for kidney or bladder problems? _____ **Yes** **No**

Have you ever had hives, skin diseases or skin rashes? _____ **Yes** **No**

Have you ever been treated for stomach problems such as ulcers? _____ **Yes** **No**

Are you on a special diet? ___ **Yes** ___ **No** _____ **Has your weight changed recently?** ___ **Yes** **No**

Yes **No** **Do you bruise easily, or bleed excessively after tooth extractions?**

Yes **No** **Are you HIV positive?**

Yes **No** **Do you smoke?** _____ **How much?** _____

Is there anything we have not asked you? _____

THIS SECTION IS FOR WOMEN ONLY

Is your menstrual cycle regular? **Yes** **No**

Are you on the "pill?" **Yes** **No**

Are you pregnant? **Yes** **No**

Signature _____ Date _____

Over Please

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DENTAL HEALTH

Reason for this visit _____

Who can we thank for referring you? _____

Yes **No** Are you having dental pain? Where _____

If so, how long have you noticed it? _____

Is it sharp __, dull __, constant __, intermittent __, Aggravated by hot __, cold __, pressure on chewing __

Yes **No** Do you frequently have canker sores, painful gums, or a burning sensation in your mouth?

Yes **No** Do your gums ever bleed? If so, when? _____

When did you last have your teeth cleaned? _____

Where? _____

How frequently have you had your teeth cleaned in the last 10 years? _____

Yes **No** Do you have any teeth, which seem to have become loose or have recently shifted position?

Yes **No** Have you noticed bad breath or bad taste from your mouth?

Yes **No** Have you ever had gum boils and if so when? _____

Yes **No** Have you ever had Vincent's Infection (Trench Mouth) and if so when? _____

Have you ever had periodontal treatment before? **Yes** **No** When? _____ Who? _____

Have you ever had orthodontic treatment? **Yes** **No** When? _____

Indicate approximately the date of your last tooth extraction _____

Yes **No** Did you need any medication before or after the extraction?

Yes **No** Was there any problem with bleeding, pain, or healing after the extraction?

Yes **No** Do you avoid brushing any part of your mouth because of pain?

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with:

a) Hot foods or liquids, i.e., soup, coffee, tea, etc? **Yes** **No**

b) Cold foods or liquids, i.e., ice cream, cold fruit, etc? **Yes** **No**

c) Sweets, i.e., candy, fruit, sweet desserts, etc? **Yes** **No**

d) Sours, i.e., lemons, limes, grapefruit, etc? **Yes** **No**

Does food tend to wedge between any of your teeth? **Yes** **No**

Does your jaw ever click when you chew? Is there pain? **Yes** **No**

Yes **No** Do you clench, grit, or grind your teeth? If so, when? _____

Do you have any habits such as biting your nails, chewing on a pencil or pipe? **Yes** **No**

How often do you brush your teeth daily? _____

Please circle: Do you routinely use dental floss, rubber tip, stimulents, water pik, or electric toothbrush?

Are you presently dissatisfied with the appearance of your teeth? **Yes** **No**

Explain: _____

Are you worried about undertaking periodontal treatment? **Yes** **No**

Please add any additional information that you feel may be helpful or important in diagnosing and treating your condition.
