EDWARDS & WILSON PERIODONTICS, P.A.
4830 QUAIL CREST PLACE
LAWRENCE, KS 66049
785.843.4076

PATIENT INFORMATION [MINOR]

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY _____ SEX: M ___ F ___ MARITAL STATUS: S ___ M ___ D ___ DATE OF BIRTH _____

MOTHER'S NAME & ADDRESS _____ WORK PHONE _____ HOME PHONE _____

FATHER'S NAME & ADDRESS _____ WORK PHONE _____ HOME PHONE _____

PHYSICIAN'S NAME _____ ADDRESS _____ PHYSICIAN'S PHONE _____

LAST PHYSICAL EXAMINATION _____ FINDINGS _____

DENTAL INSURANCE COMPANY _____POLICY # _____ GROUP #_____

REFERRED BY: _____ HAVE FAMILY OR FRIENDS BEEN TREATED HERE? _____

PRESENT DENTAL CONCERNS/DENTAL HISTORY NOTES _____

_____

DENTAL HISTORY

DO YOU FEAR DENTAL TREATMENT? Y___ N___

DO YOU GRIND OR CLENCH YOUR TEETH? Y ___ N ___

DO YOUR GUMS BLEED? Y ___ N ___

HAVE YOU NOTICED YOUR BITE CHANGING? Y ___ N ___

HAVE YOU BEEN TREATED FOR PERIODONTAL DISEASE? Y ___ N ___

HAVE YOU HAD TREATMENT TO STRAIGHTEN YOUR TEETH? Y ___ N ___

HAS ANY MEMBER OF YOUR FAMILY LOST ALL OF THEIR TEETH? Y ___ N ___

HAVE YOU HAD ANY "GUM BOILS" OR SWELLINGS? Y ___ N ___

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? Y ___ N ___ IF NO, WHY NOT? _____

ARE YOUR TEETH SENSITIVE TO HOT? ___ COLD? ___ SWEET? ___

WHAT INTERVAL ARE YOU HAVING YOUR TEETH CLEANED? [PLEASE CIRCLE ONE] 3 MONTHS 4 MONTHS 6 MONTHS 12 MONTHS

WHEN WAS YOUR LAST DENTAL CLEANING? _____

HOW LONG HAVE YOU KNOWN OF YOUR PRESENT GUM CONDITION? _____

HOW LONG HAVE YOU BEEN A PATIENT OF YOUR PRESENT DENTIST? _____

HOW YOUR WOULD RATE YOUR PAST DENTAL CARE? GOOD ___ FAIR ___ POOR___

PLEASE CHECK ANY OF THE FOLLOWING ITEMS YOU USE IN MOUTH CARE:

HAND TOOTHBRUSH ___ STIMUDENTS ___ ELECTRIC TOOTHBRUSH ___ GUM STIMULATOR ___ PROXABRUSH ___ RUBBER TIP ___

TOOTH PICK ___ PERIO AID ___ WATER SPRAY DEVICE ___ FLOSS ___

BRUSHING FREQUENCY _____ FLOSSING FREQUENCY _____

MEDICAL HISTORY

HEPATITIS, JAUNDICE, OR LIVER DISEASE Y ___ N ___

EPILEPSY, CONVULSION, FAINTING SPELLS Y ___ N ___

HEART MURMUR Y ___ N ___

HEART TROUBLE OR STROKE Y ___ N ___

HIGH BLOOD PRESSURE Y ___ N ___

ARTERIOSCLEROSIS Y ___ N ___

SHORTNESS OF BREATH Y ___ N ___

EMPHYSEMA Y ___ N ___

CHEST PAIN Y ___ N ___

SWELLING IN ANKLES Y ___ N ___

TUBERCULOSIS Y ___ N ___

KIDNEY DISEASE OR INFECTION Y ___ N ___

DIABETES Y ___ N ___
ANY BLOOD RELATIVE Y ___ N ___

ARTHRITIS OR RHEUMATISM Y ___ N ___

STOMACH OR GASTRIC DISORDER Y ___ N ___

GLAUCOMA Y ___ N ___

ASTHMA, HAY FEVER, OR ALLERGIES Y ___ N ___

DRUG REACTION TO:
CODEINE, DEMEROL Y ___ N ___
PERCOCET, PERCODAN Y ___ N ___
ASPIRIN, VALIUM, NITROUS OXIDE Y ___ N ___
TETRACYCLINE, PENICILLIN, ERYTHROMYCIN Y ___ N ___
LATEX Y ___ N ___
OTHER_____

THYROID OR PARATHYROID DISEASE Y ___ N ___

VENEREAL DISEASE Y ___ N ___

HIV/AIDS Y ___ N ___

HOSPITALIZATION FOR ILLNESS OR SURGERY Y ___ N ___

HIVES OR SKIN RASH Y ___ N ___

CANCER OR ABNORMAL GROWTH Y ___ N ___
IF YES, DID YOU HAVE RADIATION TREATMENT Y ___ N ___
OR CHEMOTHERAPY Y ___ N ___

ANEMIA OR BLOOD DISORDER Y ___ N ___

ABNORMAL BLEEDING PROBLEMS Y ___ N ___

DO YOU HAVE AN ARTIFICIAL PROSTHESIS Y ___ N ___

SUBSTANCE ABUSE/ALCOHOLISM Y ___ N ___

DO YOU TAKE ASPIRIN, ANTICOAGULANTS [BLOOD THINNERS], FISH OIL, OMEGA 3, OR FLAXSEED Y ___ N ___

DO YOU WEAR CONTACT LENSES Y ___ N ___

DO YOU BRUISE EASILY Y ___ N ___

DO YOU SMOKE Y ___ N ___
IF SO, HOW MUCH _____
HOW MANY YEARS _____

IF MALE, PROSTATE PROBLEMS Y ___ N ___

IF FEMALE:
PREGNANT OR LACTATING Y ___ N ___
TAKING ANTI-PREGNANCY DRUG Y ___ N ___
PRESENTLY IN MENOPAUSE Y ___ N ___
POST-MENOPAUSE Y ___ N ___
OSTEOPOROSIS/OSTEOPENIA Y ___ N ___
TAKING MEDICATIONS FOR OSTEOPOROSIS/OSTEOPENIA Y ___ N ___
[I.E. FOSAMAX, OTHER BISPHOSPHONATES] _____

ANY SERIOUS ILLNESS NOT LISTED Y ___ N ___

DESIRE NITROUS OXIDE [LAUGHING GAS] SEDATION Y ___ N ___

PRESENTLY UNDER A PHYSICIANS CARE Y ___ N ___

TAKING ANY MEDICATION NOT LISTED Y ___ N ___

TAKING VITAMINS Y ___ N ___

ALLERGIC TO DENTAL ANESTHETIC Y ___ N ___

AWARE OF RECENT WEIGHT CHANGE Y ___ N ___

OFTEN EXHAUSTED OR FATIGUED Y ___ N ___

SUBJECT TO FREQUENT HEADACHES Y ___ N ___

A NERVOUS PERSON Y ___ N ___

UNDER UNUSUAL STRESS OR TENSION Y ___ N ___

TAKING NERVE OR SLEEPING PILLS Y ___ N ___

OFTEN UNHAPPY OR DEPRESSED Y ___ N ___

TAKING ANTIDEPRESSANT MEDICATION Y ___ N ___

TAKING HERBAL SUPPLEMENTS Y ___ N ___

MEDICAL HISTORY NOTES

_____

_____

_____

_____

_____

_____

PLEASE WRITE BELOW OR ATTACH A LIST OF CURRENT MEDICATIONS AND DOSAGE: [INCLUDING OVER THE COUNTER MEDICATIONS]

_____

_____

_____

_____

_____

PATIENT SIGNATURE [PARENT SIGNATURE IF MINOR] _____

* ANY ACCOUNT NOT PAID WITHIN 90 DAYS IS SUBJECT TO FINANCE CHARGE AT RATE OF 1.5% PER MONTH.