Ana J. Amaya, D.D.S., M.S., Inc.
Diplomate of the American Board of Periodontology

Practice Limited to Periodontics and Dental Implants

PATIENT HISTORY AND INFORMATION

Name ______________________ Today's Date __________ Age ________ Birth Date __________ Marital Status _______

Address ______________________ City ______________ Zip __________ Phone ____________

Email ______________________ Cell Phone ____________

To confirm appointments, how would you like to be notified? Email ❑ Home Phone ❑ Call Cell Phone ❑ Text ❑

Occupation ______________________ Employed By ______________________

Business Address ______________________ City ______________ Zip __________ Phone ____________

Name of Spouse ______________________ Spouse Employed By ______________________

Occupation ______________ Business Address ______________________ Phone ____________

In case of emergency, who may we contact? ______________________ Phone ______________________

Name of Dentist ______________________ City ______________ How Long? ____________

Name of Physician ______________________ City ______________ Last Physical ____________

Referred to this office by ______________________

What is your reason for seeking periodontal care? ______________________

Primary Dental Carrier Insurance Co.

____

Address ______________________

City, State, Zip ______________________

Employee ______________ Birthdate ______________

Group No. ____________ Soc. Sec. No. ______________

Secondary Dental Carrier Insurance Co.

____

Address ______________________

City, State, Zip ______________________

Employee ______________ Birthdate ______________

Group No. ____________ Soc. Sec. No. ______________

MEDICAL HISTORY

Your general health constitutes an important factor, and in combination with other causes, may influence the course of periodontal disease. To assure your health during therapy and to assist in establishing a thorough diagnosis for successful treatment, please complete this confidential form.

Please Circle "yes" or "No" to Each Item NOTES

1. Do you consider yourself to be in good health? YES NO
2. Are you being treated by a physician now? YES NO
   If so, what for? ______________
3. Are you taking **any** drugs, prescribed medications, or supplements? YES NO
   Please list *(include birth control and over counter)*
   ____
4. Have you been hospitalized or had surgery within the last five years? YES NO
   If yes, what for? ______________________
5. Indicate which of the following you have had or have at present. **Circle "Yes" or "No" to EACH ITEM**

Condition			Condition			Condition		
Heart Failure..................	YES	NO	Artificial Joints (hip, knee, etc.).....	YES	NO	Hepatitis B (Serum).........................	YES	NO
Heart Disease or Attack.....	YES	NO	Kidney Trouble.........................	YES	NO	Venereal Disease............................	YES	NO
Angina Pectoris................	YES	NO	Ulcers..................................	YES	NO	AIDS..	YES	NO
Congenital Heart Disease...	YES	NO	Diabetes................................	YES	NO	H.I.V. Positive...............................	YES	NO
Heart Murmur.................	YES	NO	Thyroid Problems.....................	YES	NO	Cold Sores/Fever Blisters..................	YES	NO
High Blood Pressure.........	YES	NO	Glaucoma...............................	YES	NO	Blood Transfusion............................	YES	NO
Arteriosclerosis................	YES	NO	Cosmetic Surgery.....................	YES	NO	Hemophilia.....................................	YES	NO
Mitral Valve Prolapse.........	YES	NO	Emphysema............................	YES	NO	Anemia..	YES	NO
Artificial Heart Valve..........	YES	NO	Chronic Cough.........................	YES	NO	Sickle Cell Disease..........................	YES	NO
Heart Pacemaker.............	YES	NO	Tuberculosis............................	YES	NO	Bruise Easily..................................	YES	NO
Heart Surgery..................	YES	NO	Asthma.................................	YES	NO	Liver Disease..................................	YES	NO
Rheumatic Fever.............	YES	NO	Hay Fever..............................	YES	NO	Yellow Jaundice...............................	YES	NO
Arthritis..........................	YES	NO	Allergies or Hives......................	YES	NO	Epilepsy or Seizures.........................	YES	NO
Rheumatism...................	YES	NO	Sinus Trouble..........................	YES	NO	Fainting or Dizzy Spells.....................	YES	NO
Cortisone Medicine..........	YES	NO	Radiation Therapy.....................	YES	NO	Nervousness..................................	YES	NO
Drug Addiction.................	YES	NO	Chemotherapy..........................	YES	NO	Psychiatric Treatment........................	YES	NO
Stroke...........................	YES	NO	Hepatitis A (infectious)................	YES	NO	Developmentally Disabled..................	YES	NO

6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?..YES NO

   If yes, please list: ______________________

NOTES

7. Do you consider yourself to be under mental or emotional stress? YES NO
8. Have you ever had excessive bleeding requiring special treatment? YES NO
9. Do you have frequent colds or sinus trouble? YES NO
10. Do you have frequent headaches? YES NO
11. Do injuries or cuts heal very slowly? YES NO
12. Do you have shortness of breath with mild exertion? YES NO
13. Do your ankles ever swell? YES NO
14. Do you smoke? How many packs per day? ________ YES NO
15. Have you ever had x-ray treatment for a tumor? YES NO
16. Are you on a special diet or restricted diet now? YES NO
    If so,why? ________________________________
17. Do you have or have you had any disease, condition or problem not listed? YES NO
    If yes, please list: ____________________________
    FOR WOMEN ONLY:
18. Are you pregnant? If yes, what month? ________ YES NO
19. Are you nursing? YES NO
20. Are you taking birth control pills? YES NO
21. Are you menopausal? YES NO

DENTAL HISTORY

1. Are you experiencing discomfort from your mouth at this time? YES NO
2. Date of last dental appointment ______________________
   What was done? ________________________________
3. How often have you had your teeth cleaned in the past five years?
   ____
4. Have you had previous periodontal (gum) treatment? YES NO
   If so, when? ____________________________________
5. Do your gums ever bleed when you brush or floss? YES NO
6. Have you noticed any loose teeth or change in your bite? YES NO
7. Do you have difficulty chewing on either side of your mouth? YES NO
8. Are you dissatisfied with the appearance of your teeth? YES NO
9. Have you noticed any mouth odors or bad tastes? YES NO
10. Do you often develop cold sores or other oral lesions? YES NO
11. Are any of your teeth generally sensitive to heat, cold, chewing sweets? YES NO
12. Are you aware of grinding or clenching your teeth? YES NO
13. When you chew, do you have clicking, popping or pain in your jaw joints? YES NO
14. Have you ever been treated for pain in the jaw joints? YES NO
15. Have you ever had orthodontic treatment (braces)? YES NO
16. How often do you brush your teeth? __________________
    What type of toothbrush? ❑ Hard ❑ Medium ❑ Soft ❑Electric
17. Do you use dental floss or toothpicks between your teeth? YES NO
18. Rate the importance you place upon keeping your remaining natural teeth:
    1 2 3 4 5
    Extremely Important — Not Important
19. Are you apprehensive about dental treatment YES NO
    If so, what is your biggest fear? ____________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

❑ Check here that you have received a copy of This office's Notice of Privacy Practices. It is available to you in office and on our website.

Patient Signature ____ Date ____________________
(Parent or Guardian)

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