

TOWSON PERIODONTAL ASSOCIATES

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Practice Limited to Periodontics

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REGISTRATION

Patient's Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Telephone: Home _____ Work _____ Cellular _____ Fax _____

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Minor _____ Date of Birth _____ Age _____ Social Security No. _____

Employer _____ Occupation _____

Business Address _____ Business Phone No. _____

Name of Spouse _____ Spouse's Employer _____

Spouse's Date of Birth _____ Spouse's Social Security No. _____

Referred by _____

Person Responsible for Payment of Account _____

Address, if different from above _____

Dental Insurance Company _____

Medical Insurance Company _____

Spouse's Dental Insurance Company _____

Spouse's Medical Insurance Company _____

Medical History

Physician's Name _____

Date of last physical exam _____ Do you have or have you had any of the following?

Please indicate with a check mark ()

<input type="checkbox"/> Any heart problems	<input type="checkbox"/> Allergies to medicines	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Allergies to drugs	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Daily Aspirin
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Allergies to _____	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Fosamax
<input type="checkbox"/> Circulatory problems		<input type="checkbox"/> Stroke	<input type="checkbox"/> Actonel
<input type="checkbox"/> Nervous problems	<input type="checkbox"/> Anemia	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Boniva
<input type="checkbox"/> Radiation treatments	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Areida
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Zometa
<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Diabetes/Hypoglycemia	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Coumadin
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Herbal medications
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Herpes	<input type="checkbox"/> Other?	<input type="checkbox"/> Intestinal problems
<input type="checkbox"/> Do you smoke?	<input type="checkbox"/> Malignancies		
How Much?	<input type="checkbox"/> Measles	Ladies, Are you pregnant?	
	<input type="checkbox"/> Mumps	Are you taking any of	Blood Pressure: S ___/D ___
<input type="checkbox"/> Allergies to anesthetics	<input type="checkbox"/> Psychiatric care	the following medications?	

List current medications and dose: _____

List all hospitalizations: _____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. _____

Is there anything that you would like to discuss privately with the doctor? _____

OTHER SIDE PLEASE!

YOUR DENTAL HISTORY

Are you currently experiencing pain from your mouth? Yes No
 Have you ever had periodontal treatment? Yes No
 Has periodontal disease been found in your mouth before? Yes No
 Have you completed any recent dental procedures? What? Yes No
 Do you fear dental treatment? Yes No
 Have you had any teeth extracted recently? Yes No
 Can you chew satisfactorily? Yes No
 Have you had many cavities? Yes No
 Are you satisfied with the appearance of your teeth? Yes No
 Have you ever had trench mouth? Yes No
 Are you embarrassed by bad breath? Yes No
 Have you noticed any bad oral odors or taste? Yes No
 Have you ever had a tooth or gum abscess? Yes No
 Are your teeth sensitive to hot or cold drinks, sweets, chewing, or touch? Yes No
 Have you noticed any rough, sharp, or uneven fillings? Yes No
 Does food catch or wedge between your teeth? Yes No
 Have you noticed bleeding during brushing, flossing, or eating? Yes No
 Do you have any loose teeth? Yes No
 Are your gums receding? Yes No
 Have you noticed itching or other sensations in your gums? Yes No
 Do your teeth come together unevenly? Yes No
 Do you awaken with "tightness" or pain in the jaw joints? Yes No
 Do your jaw joints hurt after eating, talking, yawning, or after a long day? Yes No
 Do your jaw joints pop or click? Yes No
 Do you clench or grind your teeth at night or during the day? Yes No
 Have you noticed your bite changing or any teeth moving? Yes No
 Have you noticed increasing spaces between your teeth? Yes No
 Do you have any eating disorder? Yes No
 Do you consume alcohol on a daily basis and if so, how much?

Do you take vitamins or diet supplements? Yes No
 Are you frequently dieting? Yes No
 Do you eat many sweets? Yes No
 Do you use breath mints - "Lifesavers", "Clorets", "Certs", "Tic Tacs", chewing gum, or hard candies? Yes No
 Do you drink colas, coffee, or tea with sugar? Yes No
 Do you regularly eat breakfast cereal or pastries? Yes No
 Do you regularly use "Tums", "Rolaids", or other Antacids? Yes No

Please note any items you use in your mouth care and how frequently you use each:

	Frequency	Frequency
() Toothbrush	()	() Stimulents
() Floss	()	() Rubber tip
() Water spray device	()	() Mouthwashes
() Electric toothbrush	()	() Toothpicks
() Proxabrush	()	() Other

Have you ever experienced a burning sensation of the tongue? Yes No
 Are your teeth affecting your general health in any way? Yes No
 When was your last dental exam? _____
 When was your last dental cleaning? _____
 Was it a series of cleanings? _____
 How long ago did your dentist recommend periodontal treatment? _____

If the patient is a child covered on your dental insurance as is under the age of 18, please supply the name of the school that the child attends. If the child is a full time college student, please supply the name of the college and student verification.

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the patient named on this form. I also agree to assume full responsibility for all treatments rendered. Past balances are subject to a 1.5% interest per month plus legal costs and reasonable legal fees **unless prior arrangements were made.**

Signature _____ Date _____

Doctor Signature _____ Date _____