# Ocala Periodontics & Dental Implants

Jamie N. Amir BDS, MS

Welcome to our office. We appreciate the confidence you have placed with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If you have any questions, don't hesitate to ask.

Patient Name:_____ Date of birth:_____ Sex:_____

Home address:_____ City:_____ State:_____ Zip:_____

Home phone:_____ Cell:_____ E-mail:_____

SS#:_____ Employer/Occupation:_____ Work phone:_____

Spouse's name & phone #:_____

Emergency contact & phone #:_____

Name of your medical doctor:_____ Date of last visit to medical doctor:_____

Name of your general dentist:_____ Date of last visit to general dentist:_____

Referred to us by:_____

Primary Dental Insurance:_____ Insurance phone #:_____

Subscriber's name:_____ Date of birth:_____

Member ID #:_____ Group #:_____

## DENTAL HEALTH HISTORY

Are you apprehensive about dental treatment? Y N
Do you gag easily..... Y N
Does food catch between your teeth..... Y N
Do you have difficulty in chewing your food..... Y N
Do your gums bleed easily..... Y N
Do your gums feel swollen or tender..... Y N
Are your teeth sensitive to any of the following:
- Hot foods or liquids..... Y N
- Cold foods or liquids..... Y N
- Sweets..... Y N

Do you have any of the following symptoms:
- Bad breath..... Y N
- Loose teeth..... Y N
- Pain on biting..... Y N
- Dry mouth..... Y N

Have you had treatment for gum disease..... Y N
- If yes, have you had:
- Scaling/root planing (deep cleaning)... Y N
- If yes, when?_____
- Periodontal surgery..... Y N
- If yes, when?_____

How often do you get your teeth cleaned?
_____
How often do you brush?_____
How often do you floss?_____
Do you use any other oral hygiene aids? Y N
If yes, please list:_____

Have you ever had braces..... Y N
- If yes, when?_____

Do you have any gum recession..... Y N
Have you ever had teeth removed..... Y N
- If so, for what reason?
- [ ] Loose teeth [ ] Trauma
- [ ] Cavities [ ] Broken teeth

Are you happy with your smile..... Y N
Do you prefer to save your teeth..... Y N
Do you wear dentures..... Y N
- If yes, do you experience any of the following:
- [ ] Loose dentures [ ] Difficulty chewing
- [ ] Lack of taste [ ] Lack of sensation

Does your jaw make noise..... Y N
Do you clench or grind your teeth..... Y N
Does it hurt when you chew or open wide..... Y N
Do you have earaches or pain in front of the ears..... Y N
Do you have any jaw symptoms or headaches upon waking in the morning..... Y N
Have you had a blow to the jaw (trauma)..... Y N
Have you ever noticed slow-healing sores in or about your mouth..... Y N
Is there anything else we should know about?
_____
_____
_____

# MEDICAL HEALTH HISTORY

**Do you have, or have you had, any of the following?**

Heart Problems:
- Heart murmur..... Y N
- Angina..... Y N
- High blood pressure..... Y N
- Low blood pressure..... Y N
- Previous heart attack..... Y N
- Congestive heart failure..... Y N
- Rheumatic fever..... Y N
- Rheumatic heart disease..... Y N
- Pacemaker..... Y N
- Damaged heart valves..... Y N
- Artificial heart valve..... Y N
- Other congenital heart defects..... Y N

Blood Problems:
- Easy bruising..... Y N
- Abnormal bleeding..... Y N
- Blood disease (anemia)..... Y N
- Ever require a blood transfusion..... Y N

Allergy Problems:
- Hay Fever..... Y N
- Sinus problems..... Y N
- Skin rashes..... Y N

Gastrointestinal problems:
- Ulcers..... Y N
- Gastric bleeding..... Y N
- Weight gain or loss..... Y N
- Special diet..... Y N
- Constipation/Diarrhea..... Y N

Bone or Joint Problems:
- Arthritis..... Y N
- Back or neck pain..... Y N
- Joint replacement..... Y N
- Osteopenia/Osteoporosis..... Y N

Lung Problems:
- Asthma..... Y N
- Bronchitis..... Y N
- COPD..... Y N
- Emphysema..... Y N
- Shortness of Breath..... Y N

Neurological problems:
- Fainting Spells or Seizures..... Y N
- Epilepsy..... Y N
- Strokes..... Y N
- Frequent or severe headaches..... Y N
- Dementia/Alzheimer's..... Y N
- Mental health disorders..... Y N

Immunological/Hormonal problems:
- Thyroid problems..... Y N
- Persistent cough or swollen glands..... Y N
- Recurrent infections..... Y N
- Diabetes..... Y N
- Recent HbA1C if diabetic?_____

Liver problems:
- Hepatitis..... Y N
- Cirrhosis or diminished liver function. Y N

Kidney or bladder problems..... Y N
Herpes or other STD..... Y N
HIV-Positive/AIDS..... Y N
Cancer/Tumor..... Y N
Do you drink alcohol..... Y N
- If yes, how much?_____

Do you currently smoke ..... Y N
- If yes, how much per day?_____
- If yes, for how many years?_____

Have you ever smoked..... Y N
- If yes, for how long?_____

History of alcohol or drug abuse..... Y N
**Premedication required by physician**..... Y N
Do you have any condition, disease, or problem not listed that you feel we should know about? Y N
If yes, please describe_____
_____
_____

**Are you allergic, or have you reacted adversely, to any of the following?**

- Local anesthetics ("Novocaine")..... Y N
- Penicillin or other antibiotics..... Y N
- Sulfa drugs..... Y N
- Sedatives, or sleeping pills..... Y N
- Aspirin, Acetaminophen, or Ibuprofen. Y N
- Codeine, Demerol, or other narcotics... Y N
- Reaction to metals..... Y N
- Latex or rubber dam..... Y N
- Other:_____ Y N

**Women**

Are you pregnant..... Y N
- If so, expected delivery date: _____

Are you nursing..... Y N
Are you taking contraceptives or other hormones..... Y N
Have you reached menopause..... Y N

**List of current Medications**

- _____
- _____
- _____
- _____
- _____
- _____
- _____

**Have you ever taken IV bisphosphonate medications to treat metastatic bone disease, multiple myeloma, or Pagets disease? If so, when?_____**

Patient/Guardian Signature:_____
Date:_____
Doctor Signature: _____
Date:_____