CASTAÑO
PERIODONTICS & DENTAL IMPLANTS

Welcome! *So that we may provide you with the best possible care please complete both sides of this dental/medical history form. All information is completely confidential. Thank You.*

Name ______________________________ Date of Birth ______________

Address ______________________________

Home Phone ______________________ Business Phone ______________________

Dentist ______________________ Town ______________________

Physician ______________________ Town ______________ Last Physical Exam ______________

Occupation/Job Title ______________________________

Employer ______________________________

What is the reason for your visit today? ______________________________

DENTAL HEALTH

Date of last dental visit? ______________ Last dental cleaning? ______________

How often do you have dental cleanings? ______________________________

How often do you brush your teeth? ______________ How often do you floss? ______________

What other dental aids do you use? (Interplak, toothpick, etc.) ______________________________

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad taste?	Yes	No
Do you frequently get cold sores, blisters, or any other oral lesions?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
A bite plate, night guard or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause ______________________________

Do your gums bleed or hurt?	Yes	No
Have your parents had gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If so, where? ______________

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing your mouth?	Yes	No
Difficulty in chewing on either side of your mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all your life?	Yes	No
Are you nervous about having periodontal treatment?	Yes	No
If so, what is your biggest concern? ______________	Yes	No

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Is there anything else you would like us to know regarding your past dental treatment? Yes No

If so, please describe ______________________________

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- OVER PLEASE -

MEDICAL HEALTH

1. Have you been under the care of a medical doctor during the past two years? .... Yes No
2. Have you taken any medication or drugs during the past two years? .... Yes No
3. Are you taking any medication, drugs, or pills now? .... Yes No

   If yes, please list name and dosage ____________________
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? .... Yes No

   If yes, please list: ____________________
5. Have you ever taken Bisphosphonate drugs (ex. Fosamax, Boniva etc.) .... Yes No
6. Have you been a patient in the hospital during the past five years? .... Yes No
7. Indicate which of the following pertain to you:

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious), B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problem	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artifical Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Pheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Stroke	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Diet (Special/Pestricted)	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Kidney Trouble	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Cancer	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Have you been instructed to premedicate with an antibiotic prior to any surgical procedure or dental treatment? .... Yes No

   If so, which one ____________________
9. Have you lost or gained more than 10 pounds in the past year? .... Yes No
10. Do you have or have you had any disease, condition or problem not listed? .... Yes No

    If so, please list ____________________
11. **Women:** Are You: **Pregnant?** Yes, ____ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary in order to provide me with dental care in a safe and efficient manner. I have answered all questions to be best of my knowledge. Should further information be needed, you have my permission to ask the appropriate health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medications.

Patient/Guardian Signature ____________________ Date ____________

PRIMARY		**SECONDARY**	
DENTAL INSURANCE			
Insurance Company Name		Insurance Company Name	
Insurance Company Address		Insurance Company Address	
Employee	Group No.	Employee	Group No.
Social Security Number	Date of Birth	Social Security Number	Date of Birth
Employer		Employer	