

PERIODONTICS OF ELGIN. LTD.

FRANK A. MAGGIO, D.D.S.
A PRACTICE LIMITED TO PERIODONTICS
IMPLANTS ORAL MEDICINE

GENERAL INFORMATION

THE FOLLOWING INFORMATION IS CONFIDENTIAL AND FOR OUR RECORDS ONLY.

Date: _____

Patient Name: _____

Male _____ Female _____ Date of Birth _____

Marital Status _____ Spouse's Name _____

SS # _____ Spouse's SS # _____ Spouses's DOB _____

Address: _____
Street City State Zip

Telephone: Preferred #
Home _____
Work _____
Cell _____
Can you receive text messages? Y or N

E-mail address: _____

Employer: _____

Position: _____

Business address: _____
Street City State Zip

Business telephone: _____

Spouse Employed by: _____

Business Address: _____

Name of your Referring Dentist: _____

How long have you been under his/her care? _____

Who may we thank for referring you to this office? _____

Are you covered by dental insurance? YES or NO

Dental Insurance Carrier(s)

PLEASE BRING YOUR DENTAL INSURANCE CARD(S) , WE WILL MAKE A COPY

Primary Dental Insurance Name and Address

Policy Number _____ ID Number _____

Person Responsible for this Account _____

Secondary Dental Insurance

Policy Number _____ ID Number _____

Person Responsible for this Account _____

Person to Notify in case of Emergency _____

Relationship to you _____

Phone Number _____

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MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

Name, address, and phone number of Physician (Medical Doctor) _____

CIRCLE ONE

YES NO Do you feel that you are in good general health?
YES NO Are you now under the regular care of a physician? If so, for what? _____

YES NO When was your last physical examination? _____
YES NO Have you had any major operations, hospitalization or illnesses? If so, what & when? _____

YES NO Are you taking any medication or herbals? If so, for what?
MEDICATION DOSAGE FOR HOW LONG TAKING

AN ADDITIONAL SHEET IS PROVIDED IF NEEDED (Last Page).

YES NO Have you had any unusual reaction or allergies to any foods?
If so, please list:

Have you ever had a reaction to any of the following medications: (PLEASE CHECK)

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sleeping pills
<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Codeine	<input type="checkbox"/> Dental Anesthetic
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex
<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Other _____

YES NO Do you Smoke?
 YES NO Do you consume alcohol?
 YES NO Are you on a diet of any kind?
 YES NO Has any member of your family had tuberculosis, diabetes, heart disease, allergies,
 bleeding problems or cancer? If so, who? _____

Do you have or have you ever had: (PLEASE CHECK)

<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Painful or frequent urination
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Ulcers (stomach or duodenal)
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney or Bladder trouble
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid or parathyroid disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma or difficulty breathing
<input type="checkbox"/> Abnormal thirst	<input type="checkbox"/> Anemia or blood disorder
<input type="checkbox"/> Tumors	<input type="checkbox"/> Frequent vomiting or diarrhea
<input type="checkbox"/> Radiation therapy	<input type="checkbox"/> Arthritis or Rheumatism
<input type="checkbox"/> Problems in healing	<input type="checkbox"/> Painful or swollen joints
<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Rashes or skin disorders
<input type="checkbox"/> Allergies	<input type="checkbox"/> Dizziness or light headaches
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Frequent fractures or dislocations	<input type="checkbox"/> Sexually related diseases
<input type="checkbox"/> Cortisone or other steroids	<input type="checkbox"/> Joint replacement, HIP/KNEE (circle one)
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Osteopenia or Osteoporosis (circle one)
<input type="checkbox"/> Hepatitis, jaundice or other liver diseases	
<input type="checkbox"/> Shortness of breath or chest pains upon exertion	
<input type="checkbox"/> Tuberculosis, emphysema or other lung disease	
<input type="checkbox"/> Epilepsy, seizures, convulsions or fainting spells	
<input type="checkbox"/> Swelling of the hands, feet or eyes	

- YES NO Do you take ASPIRIN daily? 81mg or 325mg?
How many daily?_____
- YES NO Do you PRE-MEDICATE prior to any dental appointments?
Antibiotic_____
- Dosage_____
- YES NO Are you excessively nervous or depressed?
- YES NO Have you ever been treated for nervous or mental disorders?
- YES NO Do you find it necessary to sleep using two pillows?
- YES NO Have you recently gained or lost excessive amounts of weight?
- YES NO Have you had abnormal bleeding after a cut or a tooth extraction?
- YES NO Have you ever taken or are you taking a BISPHOSPHONATE for OSTEOPOROSIS?
(examples: FOSAMAX, BONIVA, RECLAST, OR ACTONEL)

WOMEN ONLY:

- YES NO Are you pregnant?
- YES NO Are you taking birth control pills?
- YES NO Do you have any menstrual problems?
- YES NO Have you reached menopause (Change of life)?
- YES NO Are you taking hormone replacement therapy?

PERIODONTICS OF ELGIN, LTD.

DR. FRANK A. MAGGIO, D.D.S.

A PRACTICE LIMITED TO PERIODONTICS

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DENTAL HEALTH

- YES NO Do you consider yourself in good dental health?
- YES NO Do you think that your teeth are affecting your health in any way?
- YES NO Are you dissatisfied with the appearance of your teeth?
- YES NO Are you dissatisfied with your chewing ability?

Have you every had:

- Orthodontic treatment (Braces)
- Oral Surgery (Extractions, etc.)
- Periodontal treatment
- Your teeth ground or bite adjusted
- A bite plate or night guard

- YES NO Have you noticed any loosening of your teeth?
- YES NO Does food tend to become caught between your teeth?
- YES NO Do your suffer from pain and/or swelling of your gums?
- YES NO Do your gums often bleed when you brush your teeth?
- YES NO Do your have any unpleasant odor or taste in your mouth?
- YES NO Are you missing any teeth?
Reasons: Decay ____ Gum Disease ____ Other Trauma ____
- YES NO Have missing teeth been replaced?
- YES NO Do you ever have any soreness, pain, clicking or popping in the area of your ears?
- YES NO Are you aware that recent research has suggested the infected gums may increase the dangers associated with diabetes, heart disease, stroke, lung damage and/or delivering a premature/low-birth-weight baby?
- YES NO Are you aware that the use of bisphosphonates can create possible jaw problems?

Do you:

Clench or grind your teeth while awake or sleep?

Bite your lips or cheeks regularly?

Hold foreign objects with your teeth?

Breath primarily through your mouth?

When did you last have your teeth cleaned before this appointment? _____

How often do you see your dentist? _____

How often and when do you brush your teeth? _____

How often and when do you floss your teeth? _____

Do you use a: Hand tooth brush Electric tooth brush

Is your tooth brush: Soft Medium Hard

What else do you use to clean your teeth? (floss, toothpick, water pick, etc.) _____

How often? _____

YES NO Do you feel apprehensive when you are having a dental treatment?

YES NO Does the fear of pain make you postpone your dental treatment?

YES NO Is it important to you to keep your teeth?

YES NO Would you spend fifteen minutes a day in order to keep your natural teeth?

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Office Policy and Treatment Consent

I hereby certify that the foregoing information is correct. I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending periodontist or supervised staff for diagnostic purpose or dental treatment for myself or my child. I give my consent to the release of any information concerning my or my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits and the payment of said insurance benefits directly to the office of Periodontics of Elgin, Ltd. otherwise payable to me. I consent to the release of any information concerning my or my child's health care, advise, and treatment to another dentist. I will be responsible for any financial obligations incurred for dental treatment.

Signature _____ Guardian _____ Date _____

