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 Referring Dentist: _____

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

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

Person to Notify in case of Emergency_____

Relationship to you _____

Phone Number _____

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 _____

PERIODONTICS OF ELGIN, LTD.

FRANK A. MAGGIO, D.D.S.

A PRACTICE LIMITED TO PERIODONTICS

IMPLANTS ORAL MEDICINE

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?_____

_____

_____

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.

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

_____

_____

_____

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

____Penicillin ____Sleeping pills

____Sulfa drugs ____Tetracycline

____Codeine ____Dental Anesthetic

____Aspirin ____Erythromycin

____Latex ____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)

____Rheumatic fever ____Painful or frequent urination

____Heart murmur ____Ulcers (stomach or duodenal)

____Heart Attack

____Mitro Valve Prolapse ____Kidney or Bladder trouble

____Arteriosclerosis ____High or Low blood pressure

____Diabetes ____Thyroid or parathyroid disease

____Stroke ____Asthma or difficulty breathing

____Abnormal thirst ____Anemia or blood disorder

____Tumors ____Frequent vomiting or diarrhea

____Radiation therapy ____Arthritis or Rheumatism

____Problems in healing ____Painful or swollen joints

____Frequent headaches ____Rashes or skin disorders

____Allergies ____Dizziness or light headaches

____Glaucoma ____Sinus problems

____Frequent fractures or dislocations ____Sexually related diseases

____Condition or other steroids ____Joint replacement, HIP/KNEE (circle one)

____ HIV/AIDS ____Osteopenia or Osteoporosis (circle one)

____Hepatitis, jaundice or other liver diseases

____Shortness of breath or chest pains upon exertion

____Tuberculosis, emphysema or other lung disease

____Epilepsy, seizures, convulsions or fainting spells

____Swelling of the hands, feet or eyes

YES NO Do you take ASPIRIN daily? 81mg or 325mg?

How many daily?_____

YES NO Do you PREMEDICATE 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 Or OSTEOPENIA? (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

IMPLANTS ORAL MEDICINE

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?

PERIODONTICS OF ELGIN, LTD.

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

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_____

2000 Larkin Ave., Elgin, IL 60123 (847)697-4646 reception@perioelgin.com

PERIODONTICS OF ELGIN, LTD.

FRANK A. MAGGIO, D.D.S.

A PRACTICE LIMITED TO PERIODONTICS

IMPLANTS ORAL MEDICINE

MEDICATION	DOSAGE	FOR	HOW LONG TAKING