ACQUAINTANCE INFORMATION

Date _____

Patient Name _____

Preferred Name _____ Spouse's Name _____

Address _____

_____

Birthdate _____ Social Security # _____

Home Number_____ Work Number_____ Cell Number_____

Email Address _____

How did you learn about our office?_____ Dentist _____

Employer_____ Employer Address _____

Insured's Name_____Insured's Soc. Sec. #_____

Insured's Birthdate_____ Relationship to Patient _____

Insured's Employer _____Occupation _____

Insured's Work Number _____ Insurance Company_____

Group No._____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? yes ☐ no ☐ if yes: _____

Name of nearest relative not living with you _____Phone_____

Complete Address _____

Whom may we notify in case of an emergency?

Name _____ Phone_____Relationship to you _____

I give consent to the office of Dr. Kenneth R. Levine to obtain and to release any and all information pertaining to my medical history, insurance or billing questions.

Signature [redacted]

(OVER)

Medical History

Name of Physician _____ Last Appointment _____ Phone _____

Are you pregnant? Yes ☐ No ☐ If yes, anticipated delivery date _____

Do you wear contact lenses? Yes ☐ No ☐

Check a definite answer for each question:

Yes ☐ No ☐ Any change in your health in the past two years?

Yes ☐ No ☐ Are you currently under the care of a physician?
If yes, describe your treatment _____

Yes ☐ No ☐ Have you had any medical treatment or physician visit of any kind in the last two years?
If yes, describe _____

Yes ☐ No ☐ Have you ever had any surgical operation of any kind?
If yes, describe the surgery _____

Yes ☐ No ☐ Were you transfused at that time? _____

Yes ☐ No ☐ Have you been advised by a physician of the need for any surgery or treatment?
What treatment of surgery? _____

Do you have, or have you ever been treated for any of the following:

Yes ☐ No ☐ Allergy
Yes ☐ No ☐ Arthritis
Yes ☐ No ☐ Chronic Sinusitis
Yes ☐ No ☐ Glaucoma
Yes ☐ No ☐ Thyroid Condition
Yes ☐ No ☐ Anemia, Sickle Cell Disease
Yes ☐ No ☐ Fainting
Yes ☐ No ☐ Radiation/Chemical Therapy
Yes ☐ No ☐ Enzyme Deficiency
Yes ☐ No ☐ Asthma
Yes ☐ No ☐ Chemical/Alcohol Dependency

Yes ☐ No ☐ Mental Disorders
Yes ☐ No ☐ AIDS or HIV
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Diabetes
Yes ☐ No ☐ Epilepsy, Seizures
Yes ☐ No ☐ Prolonged Bleeding
Yes ☐ No ☐ GI Problems
Yes ☐ No ☐ Kidney Disorder
Yes ☐ No ☐ Hepatitis
Yes ☐ No ☐ Ulcers
Yes ☐ No ☐ Anorexia, Bulimia

Yes ☐ No ☐ Heart Problems
Yes ☐ No ☐ Heart Murmur
Yes ☐ No ☐ Mitral Valve Prolapse
Yes ☐ No ☐ Valve Replacement
Yes ☐ No ☐ Low Blood Pressure
Yes ☐ No ☐ High Blood Pressure
Yes ☐ No ☐ Pacemaker Type
Yes ☐ No ☐ Shortness of Breath
Yes ☐ No ☐ Rheumatic Fever
Yes ☐ No ☐ Hip or Joint Replacement
Yes ☐ No ☐ Venereal Disease/Herpes II
Yes ☐ No ☐ Sleep Apnea

Yes ☐ No ☐ Have you ever had an allergic reaction or been told not to take any medication?
If yes, describe _____

Yes ☐ No ☐ Are you currently taking any prescription drugs of any kind?
(ex. Birth Control, Hormone, Diet) If yes, describe _____

Yes ☐ No ☐ Are you currently taking any non-prescription drugs?

Yes ☐ No ☐ Do you use any tobacco products? Daily intake _____

Yes ☐ No ☐ Have you ever had Botox and/or Dermal Fillers? When _____

History of Biophosphonates? (Oral) Fosamax, Actonel, Boniva, (IV) Zometa, Aredia
When and for how long? _____

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNATURE [redacted] DATE _____

KENNETH R. LEVINE, D.D.S.
Periodontics & Dental Implants
8333 West McNab Road, Suite 104, Tamarac / Fort Lauderdale, FL 33321 (954) 722-1100, ext.2

Periodontal Risk Assessment Questionnaire

for _____ Date_____

TOBACCO USE

Tobacco use is the most significant risk factor for gum disease.

Do you now or have you ever used the following:

	Amount per day	*Used for how many years*	*If you quit, list what year*
☐Cigarette	_____	_____	_____
☐Cigar	_____	_____	_____
☐Pipe	_____	_____	_____
☐Chew	_____	_____	_____
☐Snuff	_____	_____	_____

HEART ATTACK/ STROKE

Untreated gum disease can increase your risk for heart attack and stroke.

Do you have any other risk factors for heart disease or stroke?

☐ Family history of heart disease ☐ Tobacco use
☐ High cholesterol ☐ High blood pressure

If you have any of these other risk factors it is especially important for you to always keep your gums as healthy and inflammation free as possible to reduce your overall risk for heart attack and stroke.

MEDICATIONS

A side effect of some medications can cause changes in your gums.

Have you ever taken any of the following medications:

☐ Dilantin anti-seizure medication.
☐ Calcium Channel Blocker blood pressure medication (such as Procardia, Cardizem, Norvasc, Verapamil, etc.).
☐ Cyclosporin immunosuppresant therapy.

GENETIC

The tendency for gum disease to develop can be inherited.

Has anyone on your side of the family had gum problems (e.g. your mother, father, or siblings):

☐ yes ☐ No

CONTAGIOUS

The bacteria which cause gum disease may be spread to a spouse or the family.

Has anyone in your immediate family been tested or treated for gum problems? If so, whom?

☐ Spouse ☐ Children

FEMALES

Females can be at increased risk for gum disease at different points in their life.

The following can adversely affect your gums. Please check all that apply:

☐ Pregnant ☐ Nursing ☐ Osteoporosis
☐ Taking birth control pills
☐ Taking hormone supplements
☐ Infrequent care during previous pregnancies

Blood Sugar

DIABETES

Gum disease is a common complication of diabetes. Untreated gum disease makes it harder for diabetics to control their blood sugar.

IF YOU *ARE* DIABETIC,

How is your diabetes control? ☐good ☐fair ☐poor

Are you prone to diabetic complications? ☐yes ☐no

How do you monitor your blood sugar?_____

Who is your physician for diabetes?_____

IF YOU *ARE NOT* A DIABETIC,

Any family history of diabetes? ☐ yes ☐no

Have you had any of these *warning signs of diabetes*?

☐ frequent urination ☐excessive thirst

☐ excessive hunger ☐ weakness and fatigue

☐ slow healing of cuts ☐ unexplained weight loss

Heart Murmur, Artificial joint prosthesis

If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and cause a serious infection of the heart muscle or your artificial joint.

Do you have a heart murmur or artificial joint?

☐yes ☐no

If so, does your physician recommend antibiotics prior to dental visits?

☐yes ☐no

Name of physician?_____

It is especially important in your case to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.

Gastric ulcers

Ulcers are caused by bacteria. When your gums are inflamed, bacteria from the mouth can travel to the gut and cause ulcers to become active. If you have been treated for ulcers you should make sure your gums are as inflammation-free as possible.

Have you ever been treated for ulcers?

☐yes ☐no

If yes,

Is the ulcer active now?

☐yes ☐no

All patients please complete the following

Have you noticed any of the following signs of gum disease?

☐ Bleeding gums during toothbrushing

☐ Red, swollen or tender gums

☐ Gums that have pulled away from the teeth

☐ Persistent bad breath

☐ Pus between the teeth and gums

☐ Loose or separating teeth

☐ Change in the way your teeth fit together

☐ Food catching between teeth

Is it important to you to keep your teeth as long as possible? ☐ yes ☐ Not really

Any particular reason why missing teeth have not been replaced?_____

Do you like the appearance of your smile? ☐ yes ☐ no

Do you like the color of your teeth? ☐ yes ☐ no

Do your teeth keep you from eating any specific food? ☐ yes ☐ No