

Jason A Boch DMD LLC

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Diplomate of the American Board of Periodontology

Patient Information

Patient Name: _____

Date of Birth: _____ Gender (M/F): _____

Name of Parent (if patient is a minor): _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone #: _____ Work phone #: _____

Cell phone #: _____ Email: _____

Employer: _____ Occupation: _____

Social Security #: _____

Dental Insurance Information

Subscriber name: _____ Subscriber date of birth: _____

Dental Insurance Company (Primary): _____

Subscriber #: _____ Employer: _____

Group#: _____

Dental Insurance Company (Secondary): _____

Subscriber name: _____ Subscriber date of birth: _____

Subscriber #: _____ Employer: _____

Group#: _____

What dental problem brings you to our office? _____

Who recommended you to our office? _____

Who is your restorative/family dentist? _____

Physician's name: _____ Phone number: _____

In case of emergency contact name/phone #: _____

Patient's Signature (or guardian) Date

Dental History

1. Do you clench or grind your teeth? _____ Do you wear an appliance for this? _____
2. Have you had any periodontal treatment or dental implants, please describe?

3. Are there any areas in your mouth that have food impaction? _____
4. Are there any areas in your mouth where you do not like how the gingiva looks? _____
5. Have you had orthodontic treatment? _____ When? _____
6. How often do you brush your teeth? ___ each day. Do you use an electric or manual toothbrush _____ Are the bristles soft/medium/hard? _____.
7. How often do you floss? ___/week. List anything else you use to clean your teeth
_____.

Medical History

1. Please list all medications that you are taking including prescription, non-prescription, and herbal supplements: _____

2. Please list any bisphosphonate medications you have taken in the past (such as Fosamax, Zometa, Actonel, Boniva, Aredia) for osteoporosis or cancer: _____
How many years have you taken it? ____ Did you ever have it administered intravenously? ____
3. Do you have any allergies including drugs, foods, latex? _____
Please List _____
4. Do you use tobacco products (smoking or smokeless) _____ For how many years? _____
Please List _____
5. Do you require antibiotic premedication before dental appointments (please list the reason for premedication and what you take)? _____
6. If you are female, are you pregnant, or is there a chance you are pregnant? _____
7. Do you drink alcohol? How much each day? _____

Patient's Signature (or guardian) Date

Please mark YES or NO and describe below:

	Yes	No
1. Do you have any medical problems/illnesses?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had any serious operations?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you take any blood thinning medications such as aspirin, Coumadin, Plavix, aggrenox? Please list below.	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any prosthetic joints, valves, or a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have a history of sinus problems or sinus treatment?	<input type="checkbox"/>	<input type="checkbox"/>
6. Any history of cardiac problems, stroke, or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
7. Is there any history of treatment for cancer?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had radiation treatment?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you bruise or swell easily, or bleed for an excessively long time?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have diabetes? How do your blood sugrars run?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have any organ transplants	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had any of the following: rheumatic fever, asthma, fainting/seizures, liver disease, HIV, gastrointestinal disease, kidney disease, tuberculosis, blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any items from above:

Do you have any other medical problems or conditions that the doctor should know about?

Patient's Signature Date

Doctor's Signature Date