DR. TAMARA JACKSON
DR. DANIEL ZEITER

PATIENT INFORMATION

(The following information is confidential and for our records only. Your confidence in our practice is greatly appreciated.)

Name (last / first) _____

Title Mrs._____ Miss _____ Ms. _____ Mr. _____ Dr. _____

Sex _____ Weight _____ Height _____ Date of Birth (D/M/Y) _____ Age _____

Residence Address _____

_____ Postal Code _____

Res. Phone _____ Cell _____ Bus. Phone _____

Email _____

Would you prefer to be contacted by email _____ or by text _____

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

Name & Address of Physician (Medical Doctor) _____

_____

Why were you referred to a periodontist? _____

Person Responsible for this Account _____

In Case of Emergency Please Notify _____

Phone No. _____ Relationship to You _____

GENERAL HEALTH

What is your estimation of your general health? GOOD • FAIR • POOR (Circle appropriate one)

Please Circle Yes or No

Are you able to climb a flight of stairs comfortably? YES NO

Do you see your physician regularly? YES NO

If so, for what? _____

When was your last physical examination? _____

Have you had any major operations, hospitalizations or illnesses? YES NO

If so, for what? _____

Are you taking any prescription medications, non-prescription medications, drugs, or natural supplements? YES NO

If so, please list: _____

_____

Have you had any unusual reactions or allergies to any drugs, pills, medications or foods (such as: rashes, difficulty breathing, swelling, nausea etc.)? YES NO

If so, please list: _____

Are you required to take antibiotics prior to dental treatment? YES NO

If so, please list: _____

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

Codeine _____ Penicillin _____ Sleeping Pills _____ Nitrous Oxide _____ Latex _____ Foods (i.e.peanuts,eggs)_____

Aspirin _____ Sulfa Drugs _____ Clindamycin ____ Dental Anaesthetic _____ Metals (incl.nickel) _____

Do you currently smoke? How many cigarettes per day? _____ For how many years? _____ YES NO

Have you smoked in the past? YES NO

Do you drink alcohol regularly? How many drinks per day? _____ YES NO

Are you on a diet of any kind? YES NO

Has any member of your biological family had malignant hyperthermia, tuberculosis, diabetes, heart disease, bleeding problems or cancer? (PLEASE CIRCLE WHICH) If yes, who? _____ YES NO

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

_____ Rheumatic fever
_____ Heart Murmur
_____ Artificial Heart Valve
_____ Angina
_____ Heart Attack
_____ Arteriosclerosis (high cholesterol)
_____ High or Low Blood Pressure
_____ Anemia or Leukemia
_____ Blood transfusions
_____ Bleeding or Bruising tendencies
_____ Stroke
_____ Allergies
_____ Asthma or difficulty breathing
_____ Sinus problems
_____ Tuberculosis
_____ Emphysema or other lung disease
_____ Shortness of breath, pain upon physical exertion
_____ Sleep Apnea
_____ Frequent headaches, dizziness or light headedness
_____ Epilepsy, seizures, convulsions, fainting spells
_____ Glaucoma
_____ Malignant hyperthermia

_____ Abnormal thirst
_____ Diabetes
_____ Thyroid or Parathyroid disease
_____ Swelling of hands, feet or eyes
_____ Conditions requiring cortisone or steroid use
_____ Hepatitis, jaundice, or other liver diseases
_____ Painful or frequent urination
_____ Kidney disease or bladder trouble
_____ Heartburn, gastric reflux or stomach ulcer
_____ Frequent vomiting or diarrhea
_____ Painful or swollen joints
_____ Frequent fractures or dislocations
_____ Arthritis or Rheumatism
_____ Joint Replacement or Prosthesis
_____ Tumors or growths
_____ X-ray or radiation therapy
_____ Rash or skin disorders
_____ Immune deficiencies (HIV, AIDS, Leukemia)
_____ Problems in healing
_____ Clinical depression or anxiety
_____ Are you a blood donor

Do you have difficulty breathing when you lie down? YES NO

Have you recently gained or lost excessive amounts of weight? YES NO

Have you had abnormal bleeding after a cut or tooth extraction? YES NO

WOMEN ONLY:

Are you pregnant? YES NO

Are you nursing? YES NO

Have you reached menopause (Change of Life)? YES NO

Is there anything else that you would like to add: _____

_____

_____

DENTAL HEALTH

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? YES NO

Have you ever had:

- ❑ Orthodontic treatment (Braces)
- ❑ Oral Surgery (Extraction, etc.)
- ❑ Periodontal treatment (by a Periodontist)
- ❑ Your bite adjusted
- ❑ A bite guard or other dental appliance

Have you ever been in a vehicle accident or experienced any trauma to your jaws? YES NO

Have you noticed any loosening or drifting of your teeth? YES NO

Does food tend to get caught between your teeth? YES NO

Do you suffer from pain and/or swelling of your gums? YES NO

Do your gums bleed when you brush your teeth? YES NO

Has anyone in your family lost teeth at a young age or had gum disease? YES NO

Do you:

- ❑ Clench or grind your teeth while awake or asleep?
- ❑ Bite your lips or cheeks regularly?
- ❑ Hold foreign objects in your teeth?
- ❑ Breathe primarily through your mouth?

When was your last dental cleaning? _____

How long before that? _____

How often before that? _____

How often and when do you brush your teeth? _____

Do you use: ❑ Hand toothbrush ❑ Electric toothbrush

Is your toothbrush: ❑ Soft ❑ Medium ❑ Hard

What do you use to clean between your teeth? (floss, toothpick, waterpick, etc.) _____

How often? _____

~~YES NO~~

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

Would you like to be sedated during treatment? YES NO

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

Have you had a bad dental experience? YES NO

Would you like to elaborate? _____

_____

_____

I verify that all of the information given is true to the best of my knowledge.

Signature _____ Date (DD/MM/YY) _____

Name :_____

Address : _____

_____ DOB (dd/mm/yy)_____

What medication am I taking?	Why am I taking this medication?	How often Do I take it? What Dosage?	When did I start/stop?	Who prescribed it to me?

If you would like to have your dental claim submitted electronically to your PRIMARY INSURANCE, please fill out the following form so that we can send your claim for you during your visit. If you have secondary insurance coverage please provide the information on this form and we will provide a claim form for you to submit by mail. You will still make payment to our office on day of the treatment but you will still receive your insurance reimbursement faster, often in three days.

Primary Insurance

Name of Patient_____

Date of Birth_____

Address of Patient _____

Name of Subscriber _____
(Insurance Holder)

Date of Birth (d/m/y) _____

Relationship to patient _____

Name of Insurance Company _____

Name of Employer _____
(Past or present)

Group Plan or Policy number _____

Plan Division Number (Not all plans have) _____

Certificate or I.D Number_____

If the patient is attending school, please provide us with the name of the school.

If you have secondary insurance coverage please provide secondary insurance on the back.

Secondary Insurance

Name of Patient_____

Date of Birth_____

Address of Patient _____

Name of Subscriber _____
(Insurance Holder)

Date of Birth (d/m/y) _____

Relationship to patient _____

Name of Insurance Company _____

Name of Employer _____
(Past or present)

Group Plan or Policy number _____

Plan Division Number (Not all plans have) _____

Certificate or I.D Number_____