ANNEX

ORTHODONTICS PERIODONTICS

INSTRUCTIONS

1. Complete the form below to the best of your ability.

2. Once completed, click the “File” menu option at the top of the screen and “Save” it.

3. Attach the completed PDF form to an email and send it to: info@annexorthoperio.com.

THANK YOU

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PATIENT INFORMATION

Date ______________

Name ____ Date of birth __________________________

Home Phone ( ) ___________________

Cell Phone ( ) ___________________

Work Phone ( ) ___________________

Email address ____

Address:

Street ____

City ___________________________________ Province _______________ Postal Code ______________________

Emergency contact:

Name ______________________________ Phone ( ) ________________ Relation _______________________

REFERRAL INFORMATION

Referred by _________________________________ Family Dentist ______________________________________

Physician _________________________________ Last Seen / Reason __________________________________

DENTAL HISTORY

1. What is your biggest concern about your gums, mouth, or teeth?

Check the following conditions if they apply to you

[ ] swollen or bleeding gums
[ ] painful gums or teeth
[ ] loose teeth
[ ] bad breath or mouth odors
[ ] sensitivity to hot, cold, or sweets
[ ] increasing spaces between teeth
[ ] bad tastes
[ ]clench or grinding of your teeth
[ ]other____________________

2. When was your last visit to your family dentist and what was the nature of the treatment?

3. Have you had periodontal treatment before? If yes, when and where?

4. Have you had any Oral Surgery in the past? If yes, were ther any complications?

5. How often and when is the last time your teeth were cleaned?

6. How would you feel if you had to lose your teeth?

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MEDICAL HISTORY

Place check in the YES or NO column	YES	NO
1. Are you allergic to any medications? ______________________________	____	____
2. Have you had any serious illness, operation, or hospitalization in the past?	____	____
3. Has there been a change in your health in the last 2 years?	____	____
4. Are you a "bleeder" or have you had excessive bleeding following dental treatment?	____	____
5. Are you presently under the care of a physician?	____	____
6. Do you smoke or use tobacco products? How much?_______ How long?_______	____	____
7. Do you drink alcoholic beverages?	____	____

8. HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
High Blood Pressure	____	____	Angina	____	____	Osteoporosis	____	____
Heart Murmurs	____	____	Heart Attack	____	____	Joint Implants	____	____
Prolapsed Mitral Valve	____	____	Pacemaker	____	____	H.I.V./AIDS	____	____
Rheumatic Fever	____	____	Emphysema	____	____	Nervous Disorders	____	____
Heart Problems	____	____	Asthma	____	____	Epilepsy / Seizures	____	____
Heart Bypass Surgery	____	____	Dialysis	____	____	Cancer	____	____
Kidney Disease	____	____	Tuberculosis	____	____	Radiation / Chemo	____	____
Chemical Dependency Treatment	____	____	Stroke	____	____	Steroids Last 2 Years	____	____
Hepatitis / Liver Disease	____	____	Diabetes	____	____		____	____
Thyroid Disorders	____	____	Arthritis	____	____	**Women Only:**		
Blood disorders	____	____	Headaches	____	____	Pregnant	____	____
Bleeding Problems	____	____	Cholesterol	____	____	Breast Feeding	____	____

9. List **ANY** drugs or medicines that your are currently taking...include prescription / non-prescription drugs, Aspirin, Birth control pills, and vitamins.

DRUG	DOSAGE / HOW OFTEN?	HOW LONG?
__________	__________	__________
__________	__________	__________
__________	__________	__________
__________	__________	__________

PATIENT SIGNATURE______________________________ Date______________

To Be Filled In By Doctor

MEDICAL HISTORY REVIEWED ON: ______________ BY______________________
Baseline Blood Pressure: 1) ______________ 2) ______________ 3) ______________