

# Welcome

Dr. Burliss and Staff will strive to provide you with the best possible periodontal care. To help us meet all your periodontal healthcare needs, please complete this form in ink. If you have any questions or need assistance, please ask us - we will be happy to assist you.

## Patient Information (CONFIDENTIAL)

Patient # \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_  
Date \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated  
If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ ☐ Full Time ☐ Part Time  
Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_  
Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Whom May We Thank for Referring You? \_\_\_\_\_  
Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Driver's License# \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_  
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No  
Payment in full at each appointment.

## Dental Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_  
Ins. Co. Phone \_\_\_\_\_ Ins. Co. Fax \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_  
Secondary Dental Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/Post. Code \_\_\_\_\_  
Ins. Co. Phone \_\_\_\_\_ Ins. Co. Fax \_\_\_\_\_

Over Please



# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |   | Yes                      | No                       |  | Yes                      | No                       |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you allergic to or have you had any reactions to the following? |                          |                          |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ..... | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (e.g. novocain) .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain _____  |                          |                          | Penicillin or other Antibiotics .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Sulfa Drugs .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine? .....                                  | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking and dosage? .....   |                          |                          | Sedatives .....  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Iodine .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you currently pre-med for dental procedures? .....  | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you take medication to thin your blood? .....   | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (e.g. nickel, mercury, etc.) .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you smoke? How much? .....  | <input type="checkbox"/> | <input type="checkbox"/> | Latex Rubber .....   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Other (please list) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have or have you had any of the following?  |                          |                          | 9. Women Only:   |                          |                          |

	Yes	No
High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles .....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions .....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases .....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem .....	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired .....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement or Implant .....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis / Jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Ileitis / Colitis .....	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Chest Pains .....	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded .....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever / Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Loss .....	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>
Other .....	<input type="checkbox"/>	<input type="checkbox"/>

## Patient Dental History

Name of "General" Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |   | Yes                      | No                       |   | Yes                      | No                       |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do you think your teeth are affecting your general health in any way? .....      | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do your gums bleed while brushing or flossing? .....                             | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have sensitive teeth? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any periodontal treatment/surgery? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? .....                                     | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had sores in the mouth or on the lips that are slow to heal? ..... | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you wear dentures or partials? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have or have you ever had sinus trouble? .....                            | <input type="checkbox"/> | <input type="checkbox"/> | If yes, date of placement .....   |                          |                          |
| 7. Do you floss? How often? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have frequent headaches? .....  | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you clench or grind your teeth? .....   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (or parent if minor) \_\_\_\_\_

Doctor's Comments \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_