STEVEN R. URETSKY, D.M.D

PRACTICE LIMITED TO PERIODONTICS

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PERIODONTAL PATIENT INFORMATION QUESTIONAIRE:

Name ______________________ Age ___ Date of Birth _________ Phone (H)____________ (W) ____________
Home Address ____________________________________ City _________________ ST ____ Zip ___________
Occupation ___________________________ Employer _________________________ SS# _________________
Business Address ________________________________ City ______________ ST ____ Zip ___________
Martial Status
Spouse's Name ________________________________ (Parent or Guardian, if minor) Date of Birth ___________
Occupation ___________________________ Employer _________________________ SS# _________________
Business Address ________________________________ City ______________ ST ____ Zip ___________

DENTAL HISTORY:

FAMILY DENTIST ______________________________ City _______________ Phone ____________________

1. When was your last visit to the dentist? ____________________ What was done? ______________________
2. What is the purpose of this visit? ____
3. Is there anything else you would like to tell me about your dental/periodontal health? ___________________

MEDICAL HISTORY:

1. Are you under the care of a physician?
   If so, what are you being treated for? ____
2. Name of your physician: ____
3. Address of your physician: ____
4. Phone number of your physician: ____
5. Date of last physical examination? ____
6. Do you or have you had any of the following diseases or problems? Please check all that apply:
   - Rheumatic Fever/Rheumatic Heart Disease ....
   - Heart Murmur ....
   - Mitral Valve Prolapse ....
   - Congenital Heart Lesions ....
   - Joint Replacement Surgery ....
   - Cardiovascular Disease ....
   - Allergy ....
   - Sinus problems ....
   - Asthma or Hay Fever ....
   - Hives or skin rash ....
   - Fainting spells or seizures ....
   - Diabetes ....
   - Hepatitis, Jaundice or Liver Disease ....
   - Arthritis ....
   - Kidney problems ....
   - Tuberculosis ....
   - Venereal Disease ....
   - HIV + or AIDS ....
   - Anemia ....
   - Leukemia ....
   - Abnormal bleeding/clotting problems ....
   - TMJ headaches/face pain ....
   - Nervous condition ....
   - Epilepsy ....

7. Are you taking any of the following? Please check all that apply:
   - Antibiotics or Sulfa drugs ....
   - Anticoagulants (blood thinners) ....
   - Medicine for high blood pressure ....
   - Cortisone (steroids) ....
   - Tranquilizers ....
   - Antihistamines ....
   - Aspirin ....
   - Insulin ....
   - Digitalis or drugs for heart problems ....
   - Nitroglycerine ....

8. Please list any other medications that you are presently taking: ______________________________

   ____

9. Are you allergic or have you reacted adversely to any of the following? Please check all that apply:
   - Local anesthetics ....
   - Penicillin or other antibiotics ....
   - Sulfa drugs ....
   - Barbiturates, sedatives, sleeping pills ....
   - Aspirin ....
   - Iodine ....
   - Codeine or other narcotics ....
   - Other-Please specify ....

10. Do you have any disease, problem or condition that you think we should know about? Y / N

    If so, explain: ______________________________

    ____

WOMEN:

Are you pregnant? If so, how many months? ________

Have you or are you undergoing menopause?

If so, are you taking any medications? Name of medication: ______________________________

DENTAL INSURANCE INFORMATION:

Do you have dental insurance?

Name of insurance company: ______________________________

Name of person insured: ______________________________

Insured Policy/Group # ______________________________ SS#: ______________

TO OUR PATIENTS:

Please do not be hesitant in asking us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions. We will be happy to file your insurance form for you. Please remember that the financial obligation for your periodontal treatment is your responsibility. Your benefit coverage of this treatment is between you, your employer, and the insurance company.

PATIENT/PARENT SIGNATURE: ______________________________ Date ______________

DOCTOR SIGNATURE: ______________________________ Date ______________