X-RAYS RECEIVED ON

____

HEMA MENON, B.D.S., M.S.D.

PRACTICE LIMITED TO PERIODONTICS

100 Central Medical Building • St. Paul, Minnesota 55104

(651)646-1318

Date______________

PERSONAL INFORMATION

Name______________________________ Date of Birth______________

Spouse's Name ______________________________ Date of Birth______________

Address______________ City______________ State__________ Zip__________

Telephone: Home______________ Work______________ Spouse's Work______________

Employed By______________________ Spouse Employed By______________________

Occupation ______________________ Occupation ______________________

Address ______________________ Address ______________________

City, State, Zip ______________________ City, State, Zip ______________________

Social Security Number ______________________ Social Security Number______________________

Persons to Contact in Case of Emergency______________________ Phone______________

Referring Dentist______________________ Address______________________

Dental Insurance Company______________________ Group #______________

Secondary Dental Insurance Company______________________ Group #______________

MEDICAL HISTORY

Physician's Name______________________ City of Practice______________________

Date of Last Physical Exam ______________________________

Do you have or have you had any of the following? If so, please circle.

Aids or A.R.C.	Circulatory problems	Hepatitis B (Serum)	Pacemaker
Allergies	Cold sores	High blood pressure	Rheumatic fever
Anemia	Cortisone medication	Jaundice	Sickle-cell anemia
Arthritis	Diabetes	Kidney disorder	Sinus problems
Artificial joints or heart valves	Emphysema or Asthma	Leukemia	Stroke
Bleeding disorders	Fainting or seizures	Liver disorder	Thyroid disorder
Blood transfusions	Glaucoma	Low blood pressure	Tuberculosis
Cancer	Hayfever	Malignancies	Tumor or cyst
Chemical dependency	Heart problems	Multiple sclerosis	Ulcers
Chemotherapy	Heart murmur	Muscle weakness/paralysis	Venereal disease
Chest pain	Hepatitis A (Infectious)	Nervous problems	Other ______________

Please list medications you are taking (Prescription and over-the-counter)

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

	YES	NO
Have you been advised to premedicate before dental treatment?	☐	☐
Do you smoke or use tobacco?	☐	☐
Have you had any accidents or been hospitalized in the past 5 years?	☐	☐
WOMEN: Are you pregnant or think you might be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Have you experienced an allergic or bad reaction from the following?

☐ Aspirin ☐ Codeine ☐ Penicillin

☐ Barbiturates, sedatives, sleeping pills ☐ Local anesthetic ☐ Antibiotics

☐ Nitrous oxide ☐ Sulfa drugs

☐ Other ____

____

PLEASE TURN PAGE AND COMPLETE THE OTHER SIDE

DENTAL HISTORY

When were your last full mouth x-rays taken? ______________________________

What is your present dental problem? ______________________________

Have you ever been treated for periodontal disease? ______________________________

When was your last dental visit? ______________________________

When were your teeth last cleaned? ____________________ Performed by ☐ hygienist ☐ dentist

Have you been instructed in the care of your gums and teeth? ______________________________

How often do you brush your teeth? ______________________________

What texture brush do you use? ______ Soft ______ Medium ______ Hard

How often do you floss? ______________________________

Do your gums bleed when you brush or floss? ______________________________

Are your teeth sensitive to: ______ Hot ______ Cold ______ Sweets ______ Chewing pressure?

Do your gums feel tender or swollen? ______________________________

Have you experienced any of the following jaw problems? If so, please check.

☐ Clicking of the jaw ☐ Difficulty in chewing

☐ Pain in the joint, ear, side of face ☐ Difficulty in opening or closing

Have you had any head, neck or jaw injuries? ______________________________

Do you clench or grind your teeth while awake or asleep? ______________________________

Do you have any lumps or sores in or near your mouth? ______________________________

Do you gag easily? ______________________________

Is it important to keep your teeth? ______________________________

Have you ever had any upsetting experiences in the dental office? ______________________________

____

____

Please note any medical condition or past experience that may possibly affect your dental treatment, other patients, or our office staff.

____

____

____

I submit the above medical and dental history as accurate and complete. Please sign and date the first available line. Thank you.

1. ____________________ 6. ____________________

2. ____________________ 7. ____________________

3. ____________________ 8. ____________________

4. ____________________ 9. ____________________

5. ____________________ 10. ____________________