DR SIMS

PERIODONTICS | DENTAL IMPLANTS

DATE _____

Patient Information

Patient's Name _____ Age _____

Street Address _____ Sex _____

City, State, Zip Code _____ Birth Date _____

Home Phone ( ) _____ SS Number _____

Cell Phone ( ) _____ Email _____

Employed By _____

Business Phone ( ) _____

Relationship Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse/Parent Name _____

Spouse Employed By _____

Business Phone ( ) _____

Referred By _____ Phone ( ) _____

General Dentist _____ Phone ( ) _____

Physician _____ Phone ( ) _____

Insurance Information

Dental Insurance Co. _____

Contract Number _____

Name of Insured _____ Birth Date _____

Employer _____ SS Number _____

Relationship to Patient _____

Responsible for Bill Pay _____

Dental History

Chief Oral Complaint _____

_____

Last Dental Exam Date _____ Previous periodontal treatment? ☐ No ☐ Yes If so, when? _____

Do you have, use or take any of the following?

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long? _____
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in the mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extraction
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Water jet device
- ☐ Fluoride supplements
- ☐ Oral habits (Example: fingernail biting, cheek biting)
- ☐ Cigarettes, pipe or cigars
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental floss
- ☐ Interdental brushes
- ☐ Disclosing tablets or solution

Do you take Aspirin or any other anticoagulants? ☐ Yes ☐ No

Do you take Viagra™, Levitra™ or Cialis™? ☐ Yes ☐ No