NANCY L. NEWHOUSE, D.D.S., M.S.

NEW PATIENT INFORMATION (Please Print)

Date _____

Please answer the following questions completely. The information is for our records and is considered confidential.

Patient's name	Date of birth	Age	Social Security number	email address	Marital status

Spouse's name	Social Security number	email address

If a child, parent's name	Social Security number

Address (Street, City, State, Zip)	Home phone

Employed by	Cell phone

Employer's address (Street, City, State, Zip)	Business phone

Spouse employed by	Business phone

Spouse's employer address (Street, City, State, Zip)

Nearest relative, not living with you (Street, City, State, Zip)	Relative's phone

Person responsible for payment of account, if other than patient (Street, City, State, Zip)

Dental Insurance provider	Policy number	Secondary provider, if applicable	Policy number

Financial institutions you do business with

Whom may we thank for referring you?

HEALTH QUESTIONNAIRE (Answer all questions as completely as possible)

Yes No

❒ ❒ Are you presently under the care of a physician? If yes, for what condition?_____

❒ ❒ Name, address and phone number of physician _____

❒ ❒ Is your general health good?

❒ ❒ Have you ever been hospitalized or had a serious illness? If yes, please explain _____

_____

❒ ❒ Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?

❒ ❒ Do you bruise easily?

❒ ❒ Have you ever required a blood transfusion? If yes, explain the circumstances _____

Are you allergic or have you reacted adversely to:

❒ ❒ a. Local anesthetics?

❒ ❒ b. Penicillin or other antibiotics?

❒ ❒ c. Barbiturates, sedatives, sleeping pills?

❒ ❒ d. Aspirin?

❒ ❒ e. Codeine or other narcotics?

❒ ❒ f. Nitrous oxide analgesia ("laughing gas")?

❒ ❒ g. Have you had an unpleasant experience with any gas administered to you?

❒ ❒ Have you had any trouble with previous dental work? If yes, please explain _____

❒ ❒ Do you consider yourself a nervous or tense person?

❒ ❒ Have you ever had a malignant or non-malignant tumor removed?

❒ ❒ Have you ever had a biopsy?

❒ ❒ Do you wear a pacemaker?

❒ ❒ Do you smoke? If yes, how much? _____

❒ ❒ Are you HIV positive?

❒ ❒ Have you ever been tested for Human Immunodeficiency Virus?

Women:

❒ ❒ Are you pregnant?

❒ ❒ Are you presently taking birth control pills?

(Please continue on the reverse side)

Do you or have you ever had: (check all that apply) *06/01/09*

Yes	No		Yes	No		Yes	No	
❒	❒	Heart Trouble	❒	❒	Goiter	❒	❒	Fainting or dizziness
❒	❒	Epilepsy or convulsions	❒	❒	Arthritis	❒	❒	Hayfever or Asthma
❒	❒	Prolonged bleeding	❒	❒	Stroke	❒	❒	Eczema or Hives
❒	❒	Rheumatic Fever	❒	❒	Tuberculosis	❒	❒	Bad nose bleeds
❒	❒	Low blood pressure	❒	❒	Frequent headaches	❒	❒	Glaucoma
❒	❒	Measles	❒	❒	Rheumatic heart disease	❒	❒	Stomach trouble
❒	❒	High blood pressure	❒	❒	AIDS	❒	❒	Heart Murmur
❒	❒	Kidney or bladder trouble	❒	❒	Jaundice	❒	❒	Persistant cough
❒	❒	Cancer	❒	❒	Shortness of breath	❒	❒	Tumor
❒	❒	Anemia	❒	❒	Thyroid trouble	❒	❒	Diabetes (If yes, which type? _____)
❒	❒	Hepatitis (If yes, which type? _____)	❒	❒	Venereal disease (If yes, what disease? _____)			
❒	❒	Swollen ankles						

Have you ever taken: (check all that apply)

Yes	No		Yes	No		Yes	No	
❒	❒	Aspirin	❒	❒	Cortisone, steroids, ACTH	❒	❒	Drugs for sleep
❒	❒	Drugs for high blood pressure	❒	❒	Sulfa drugs	❒	❒	Antibiotics
❒	❒	Antihistamines	❒	❒	Tranquilizers or sedatives	❒	❒	Penicillin
❒	❒	Nitroglycerin	❒	❒	Anticoagulants			
❒	❒	Insulin or Ornase	❒	❒	Digitalis or drugs for heart trouble			

What medications have you taken in the past year? _____

_____

Do you have any condition, problem or disease not mentioned above? If yes, please explain. _____

_____

_____

THE FOLLOWING IMPORTANT HISTORY IS NECESSARY FOR YOUR PERIODONTAL DIAGNOSIS AND TREATMENT PLANNING

Why are you here? _____

Who is your general dentist? _____ For how many years? _____

When did you see your dentist last? _____ When were your teeth last cleaned? _____

How often are your teeth cleaned? _____

Yes	No		Yes	No	
❒	❒	Are you currently experiencing pain from your mouth?	❒	❒	Are your gums receding?
❒	❒	Have you ever had periodontal treatment?	❒	❒	Do you clench or grind your teeth at night or during the day?
❒	❒	Has periodontal disease been found in your mouth before?	❒	❒	Have you noticed your bite changing or any teeth moving? If yes, how long? _____
❒	❒	Have you completed any recent dental procedures? If yes, what? _____	❒	❒	Have you noticed increasing spaces between teeth?
❒	❒	Do you fear dental treatment?	❒	❒	Do your teeth come together unevenly?
❒	❒	Have you had any teeth extracted recently?	❒	❒	Do you ever awaken with "tightness" or pain in the jaw joints?
❒	❒	Can you chew satisfactorily?	❒	❒	Do your jaw joints hurt after eating, talking, yawning or a long day?
❒	❒	Have you had many cavities?	❒	❒	Do your jaw joints pop or click?
❒	❒	Are you satisfied with the appearance of your teeth?	❒	❒	Do you take vitamins or diet supplements?
❒	❒	Have you noticed any bad oral odors or tastes?	❒	❒	Do you have an imbalanced or irregular diet?
❒	❒	Have you ever had trench mouth?	❒	❒	Are you frequently dieting?
❒	❒	Have you ever had a tooth or gum abscess?	❒	❒	Do you eat many sweets or drink colas, coffee, or tea with sugar?
❒	❒	Are your teeth sensitive to hot, cold, sweets, chewing, or touch?	❒	❒	Do you use breath mints, "Lifesavers,' "Clorets," "Certs," "Tic Tacs," chewing gum or hard candies?
❒	❒	Have you noticed any rough, sharp or uneven fillings?	❒	❒	Do you regularly use "Tums," "Rolaids," or other antacids?
❒	❒	Have you had any change in the ability to catch or wedge food between	❒	❒	Do you wake up with a dry mouth or lips?
❒	❒	Have you noticed bleeding during brushing, flossing, or eating?	❒	❒	Have you experienced a burning sensation of the tongue?
❒	❒	Do you have any loose teeth?	❒	❒	Are your teeth affecting your general health in any way?

Please note any items you use in your mouth care and frequency: ❒ Toothbrush ❒ Floss ❒ Waterspray device ❒ Toothpicks ❒ Proxabrush ❒ Stimudents

❒ Rubber tip ❒ Mouthwashes ❒ Electric toothbrush ❒ Other _____

Patient's Signature _____ Date _____

Periodontist's Signature _____ Date _____