JOEL J. PIEHL, DDS

PATIENT REGISTRATION

THE FOLLOWING INFORMATION IS CONFIDENTIAL AND FOR OUR RECORDS ONLY

Today's Date ________________________

Patient's Name ____

(Please Print)

Residential Address: ____

Primary Email Address: ____

Sex _________Weight _________ Height _________ Age _________ Date of Birth ________________________

Social Security # ___________________________________ Driver's License #_____________________________

Employed by ____

Position ____

Business Address ____

Business Telephone ____

Marital Status _____________Spouse's Name ____

Spouse Social Security #______________________________Spouse Telephone ___________________________

Spouse Email Address ____

Spouse Employed by ____

Business Address: ____

Name of Dentist ____

How long have you been under his/her care? ____

Name of Physician (Medical Doctor) ________________________________Telephone#______________________

Physician's (Medical Doctor) Telephone ____

Who referred you to this office? ____

Why were you referred to a periodontist?____

If you have dental insurance, name of Insured? ____

Name and Address of Carrier ____

____ Policy Number ______________________________

Person Responsible for This Account ____

Person to Notify in Case of Emergency ____

Emergency Phone#___________________________________

GENERAL HEALTH

Circle One: What is your estimation of your general health? GOOD – FAIR – POOR

Yes No Are you now under the regular care of a physician?

If so, for what? ____

When was your last physical examination? ________________________________

Yes No Have you had any major operations, hospitalization or illnesses?

If so, for what?____

Yes No Are you taking any pills, medication or drugs?

If so, please list.____

Yes No Have you had any unusual reaction or allergies to any medications or foods?

If so, please list.____

Have you ever had a reaction to any of the following: (PLEASE CHECK)

____ Penicillin
____ Sulfa drugs
____ Codeine
____ Aspirin
____ Bisphosphonates
____ Sleeping pills (barbiturates)
____ Tetracycline
____ Dental anesthetic (Novocain)
____ Nitrous oxide (laughing gas)

Yes No Do you smoke?
Yes No Do you drink alcohol?
Yes No Are you on a diet of any kind?
Yes No Has any member of your family had tuberculosis, diabetes, heart disease, allergies, bleeding problems or cancer? If yes, who? ________________________________

Do you have or have you ever had: (PLEASE CHECK)

____ Rheumatic fever
____ Heart murmur
____ Heart attack
____ Arteriosclerosis
____ Diabetes
____ Stroke
____ Abnormal thirst
____ Tumors or growths
____ X-ray or radiation therapy
____ Problems in healing
____ Frequent headaches
____ Allergies
____ Glaucoma
____ Frequent fractures or dislocations
____ Condition requiring cortisone
____ Swelling of the hands, feet or eyes
or other steroids
____ Hepatitis, jaundice, or other liver disease
____ Shortness of breath or chest pains upon exertion
____ Obesity
____ Metabolic syndrome
____ Painful or frequent urination
____ Ulcers (stomach or duodenal)
____ Kidney or bladder trouble
____ High or low blood pressure
____ Thyroid or parathyroid disease
____ Asthma or difficulty breathing
____ Anemia or other blood disorder
____ Frequent vomiting or diarrhea
____ Arthritis or rheumatism
____ Painful or swollen joints
____ Rashes or skin disorders
____ Dizziness or light-headedness
____ Sinus problems
____ Sexually related disease
____ HIV
____ Cancer
____ Epilepsy, seizures, convulsions,
or fainting spells
____ Cognitive impairment
____ Tuberculosis, COPD, emphysema,
or other lung disease

Yes No Are you excessively nervous or depressed?
Yes No Have you ever been treated for nervous or mental disorders?
Yes No Do you find it necessary to sleep using two pillows?
Yes No Have you recently gained or lost excessive amounts of weight?
Yes No Have you had abnormal bleeding after a cut or a tooth extraction?

WOMEN ONLY:

Yes No Are you pregnant? Due date: ______________
Yes No Are you taking birth control pills?
Yes No Do you have menstrual problems?
Yes No Have you reached menopause?

DENTAL HEALTH

Yes No Do you consider yourself in good dental health?
Yes No Do you think that your teeth are affecting your health in any way?
Yes No Are you dissatisfied with the appearance of your teeth?
Yes No Are you dissatisfied with your chewing ability?
Have you ever had: _____ Orthodontic treatment (braces) _____ Your teeth ground or bite adjusted
_____ Oral surgery (extraction, etc.) _____ Periodontal treatment
_____ A bite plate or other appliance
Yes No Have you noticed any loosening of your teeth?
Yes No Does food tend to become caught between your teeth?
Yes No Do you suffer from pain and/or swelling of your gums?
Yes No Do your gums often bleed when you brush your teeth?
Yes No Do you have any unpleasant odor or taste in your mouth?
Yes No Are you missing any teeth? Reasons: Decay ____ Gum disease ____ Other ____
Yes No Have missing teeth been replaced?
Yes No Do you ever have any soreness, pain, clicking or popping in the area in front of your ears?
Do you: ____ Clench or grind your teeth while awake or asleep?
____ Bite your lips or cheeks regularly?
____ Hold foreign objects with your teeth?
____ Breathe primarily through your mouth?
When did you last have your teeth cleaned before this appointment? ___________________________________

How long before that? ____

How often do you see your dentist?____

How often and when do you brush your teeth? ____

Do you use: ____ Hand toothbrush ____ Electric toothbrush ____ If Yes, what kind?____________________

Is your toothbrush: Soft ____ Medium ____ Hard ____

What else do you use to clean your teeth? (floss, toothpick, Waterpik, etc.) ______________________________

How often? ____

Yes No Do you feel apprehensive when you are having a dental treatment?
Yes No Would you like to use nitrous oxide (laughing gas)?
Yes No Does the fear of pain make you postpone your dental treatment?
Yes No Is it important to you to keep your teeth?
Yes No Would you spend fifteen minutes a day in order to keep your natural teeth?

CONSENT FOR TREATMENT

____ ________________
Name of Patient or Legal Guardian Date

____
Signature of Patient or Legal Guardian