

Denise M. Shapiro DDS, MA · Practice Limited to Periodontics

Name: Mr. Ms. Dr. _____ Age: _____ Date of Birth _____
 Preferred Name: _____ Email: _____
 Residence Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell phone _____
 Employed by _____ Occupation _____ Person responsible for payment _____
 Business address _____ City _____ State _____ Zip _____
 Single Married Divorced Widowed Name of Spouse _____
 Name of Physician _____ Address _____ Phone _____
 Spouse employed by _____ Occupation _____ Spouse D.O.B _____
 Patient referred by _____ Dental Insurance Coverage, if any _____
 Insurance ID# _____ Insurance Group # _____ Secondary Ins. Co. _____
 Name of closest non relative to reach in case of emergency _____ Phone # _____

Health History

How would you describe your present health? _____ Date of last physical _____
 Have you ever had any serious illness? _____ if yes, please explain _____
 Are you taking any medications now? _____ If yes, please list them and quantities _____

 Are you allergic to or have you had any adverse reactions to any medication or drug (including Novocain, penicillin, or any other antibiotic)? _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE CONDITIONS LISTED BELOW?

	Y	N		Y	N		Y	N
Heart Disease (chest pain)			Joint Replacement (Knee, Other)			Asthma		
Artificial Heart Valve				Arthritis or Joint Problems				
History of Infective Endocarditis			Blood Disorders (including Anemia, Excessive Bleeding)			Cancer		
Stroke				Clotting problems			Thyroid	
Diabetes			Glaucoma or Loss of Vision			Have you taken bisphosphonates? (Fosamax, Boniva, etc.)		
High or Low Blood Pressure			Epilepsy or Fainting spells			Other- <i>please explain</i>		
Liver disorders			Nervous Disorders					
Respiratory Disorders or TB			Sinus Trouble or Hay Fever					
Ulcers			Allergies					

Do you heal normally? _____
 Have you ever received Blood Transfusions? _____ Radiation (x-ray) Treatment? _____ Chemotherapy? _____
Women: Are you pregnant? _____ Breast Feeding? _____ Taking birth control pills? _____
 Have you undergone or are you presently undergoing menopause? _____ Do you smoke? _____ If yes, how much each day? _____
 Do you drink alcohol? _____ If so, how much each day? _____ Have you ever tested positive (+) for HIV? _____ Does your occupation or
 lifestyle put you at risk for AIDS virus? _____

PERIODONTAL HISTORY

What is your present dental problem? _____
 Have you had periodontal treatment? If so, please explain _____
 Are your teeth sensitive to Hot? _____ Cold? _____ Sweets? _____
 Have any of your teeth shifted? _____ Have any of your teeth loosened? _____
 Are you aware of bleeding, bad taste or bad odor in your mouth? _____
 Do you clench or grind your teeth? _____ During the day? _____ During the night? _____

I understand that it is my responsibility to notify the doctor of any medical changes. I also understand that I am financially responsible for all charges whether or not paid by my insurance company. Interest will be charged at a rate of 1.5% per month which will be added to any outstanding balance. If the account is referred to an attorney for collection, the patient or responsible person will pay attorney's fee of this balance and all court costs incurred. I have read and understand the above information.

 Patient Signature

 Responsible Party Signature

Date: _____