MICHAEL S. WOJCIK, D.D.S., M.S. • PETER LEONE, D.D.S., M.S.

Periodontal Specialties

8130 CONSTITUTION
STERLING HEIGHTS, MI 48313
(586) 268-5520
FAX (586) 268-1288

35054 23 MILE ROAD
NEW BALTIMORE, MI 48047
(586) 725-5556
FAX (586) 725-5672

15870 19 MILE ROAD
CLINTON TOWNSHIP, MI 48038
(586) 412-0090
FAX (586) 412-0709

Date _____

Name _____ Date of Birth _____ Soc. Sec. No. _____

Address _____ City _____ Zip _____ Phone _____ Cell _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Name of Spouse _____ Birthdate of Spouse _____

Spouse's Employer _____ Occupation _____

Business Address _____ Business Phone _____

Referred By _____ Address _____

Family Dentist _____ Address _____

Family Physician _____ Address _____

Dental Insurance Carrier _____ Group No. _____

Relationship to Subscriber _____ Subscriber's Soc. Sec. No. _____

Patient's Email _____

MEDICAL HISTORY

	YES	NO
1. Do you consider yourself to be in good health?	☐	☐
Approximate date of last physician examination _____		
2. Are you being treated for any condition by a physician now?	☐	☐
3. Are you taking any medications at this time?	☐	☐
If so, what kind _____		
3a. Are you taking any aspirin?	☐	☐
4. Have you had any blood transfusions within the last 10 years?	☐	☐
5. Have you ever had an operation or serious illness?	☐	☐

6. As far as you know, are you allergic to any of the following medicines? Please check:

- ☐ Local anesthetic (novocaine)
- ☐ Penicillin or any other antibiotics
- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Other _____

7. Have you ever had any of the following? Please check:

- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Stroke
- ☐ High/Low Blood Pressure
- ☐ Swollen ankles
- ☐ Chest pain / Shortness of breath
- ☐ Congenital Heart Lesions
- ☐ Blood Disorders (Bleeding, Anemia)
- ☐ Jaundice, hepatitis
- ☐ Ulcers
- ☐ Asthma, hay fever
- ☐ Tuberculosis/Persistent cough
- ☐ Artificial Joint
- ☐ Kidney or bladder disorders
- ☐ Disease of the thyroid
- ☐ Hypoglycemia
- ☐ Diabetes (sugar disease)
- ☐ Family history of Diabetes
- ☐ Cancer or Tumor
- ☐ Canker or Cold sores
- ☐ Venereal Disease
- ☐ HIV Positive or AIDS
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Injury to face or jaws
- ☐ Psychiatric treatment
- ☐ Eye disorders, glaucoma
- ☐ Arthritis, rheumatism
- ☐ Frequent, severe headaches
- ☐ Cortisone, hydrocortisone or ACTH
- ☐ X-Ray treatment or Radiation

8. Have you been under more than average tension lately?	☐	☐
Source _____		
9. Do you smoke?	☐	☐
What and how much? _____		
10. Have you noticed any recent increased tendency for your skin to bruise?	☐	☐

WOMEN ONLY

	YES	NO
11. Are you taking birth control pills?	☐	☐
12. Are you pregnant at the present time?	☐	☐
13. Have you undergone, or are you undergoing menopause?	☐	☐

DENTAL HISTORY

14. Are you or have you recently been experiencing pain in your mouth or face?	☐	☐

15. Have you ever had? Please check:

- ☐ Teeth extracted
- ☐ Orthodonic treatment (braces)
- ☐ Periodontal (gum) treatment
- ☐ Vincent's Infection or trench mouth
- ☐ Removable bridges
- ☐ Bleeding gums
- ☐ Bad odors or taste

16. Do you have your teeth cleaned regularly?	☐	☐
How often? _____ How long did it take? _____ Polishing/Scaling _____		
17. Do you brush your teeth regularly?	☐	☐
18. Do you clean between your teeth regularly?	☐	☐
19. Have you ever had oral hygiene instruction?	☐	☐
20. Are you dissatisfied with the appearance of your teeth?	☐	☐
21. Do you think that your teeth are changing position or drifting?	☐	☐
22. Do you have any difficulty chewing?	☐	☐
23. Have you noticed any loose teeth?	☐	☐
24. Do your teeth ever feel sore when you bite on them?	☐	☐
25. Do you ever have pain in the region in front of your ears?	☐	☐
26. Do your jaws click or pop when you chew?	☐	☐
27. Do you clench, grit or grind your teeth in the daytime or while you are sleeping?	☐	☐
28. Do you have any habits such as biting your nails, chewing your pencil, etc.?	☐	☐
29. Does food wedge between any of your teeth?	☐	☐
30. Are your teeth sensitive to cold, heat or sweets?	☐	☐
31. Is there any health information which was not asked, which you may feel may influence dental treatment?	☐	☐
What? _____		

As a courtesy, Periodontal Specialties may submit claims to my dental insurance. I authorize release of any information necessary to do so and direct payment to the dentist or dental entity. I understand I am responsible for all charges, including any collection fees incurred by the practice.

_____

Patient Signature or Parent, if Patient is a minor

_____

Doctor Signature