Eric Guirguis,D.D.S., M.S.D.
Periodontal Specialists, Inc.

Elyria - (440) 365-0455
Westlake - (440) 835-8883

Patient Information

Title First Name M.I. Last Name Date

I prefer to be called Email:

Address City State Zip

Home Phone Cell Phone Business Phone Ext.

Preferred Contact # Social Security # **Gender** ☐ Male ☐ Female

Date of Birth / / **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

How did you find out about us?

Other family members seen by us:

Emergency Contact

Title First Name M.I. Last Name Suffix

Relationship to Patient

Home Phone Cell Phone Business Phone Ext.

Responsible Party

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other:

Title First Name M.I. Last Name Suffix

Address City State Zip

Home Phone Business Phone Ext.

Date of Birth / / Social Security # Driver's License #

Employer

Primary Insurance

Do you have a Primary Insurance? ☐ Yes ☐ No Does it have Dental Coverage? ☐ Yes ☐ No

Company Name

Company Address City State Zip

Company Phone # **Group #** (Plan, Local or Policy #)

Insured's Name **Relationship to Patient**

Insured's Date of Birth / / **Insured's Employer**

Insured's Employer Address

Secondary Insurance

Do you have a Secondary Insurance? ☐ Yes ☐ No Does it have Dental Coverage? ☐ Yes ☐ No

Company Name

Company Address City State Zip

Company Phone # **Group #** (Plan, Local or Policy #)

Insured's Name **Relationship to Patient**

Insured's Date of Birth / / **Insured's Employer**

Insured's Employer Address

Dental Information

Previous or Referring Dentist: Phone Number:

When was your last dental visit? What was done?

When were x-rays taken last? When was your last dental cleaning?

Reason for today's visit: Are you in pain? ☐ Yes ☐ No For how long?

Please rate your current dental health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How do you feel about your smile?

How many times a day do you brush? How many times a week do you floss?

What type of toothbrush do you use? ☐ Hard ☐ Medium ☐ Soft

Are you fearful of dental treatment? ☐ Yes ☐ No Please explain:

Have you ever had trouble getting numb or had reactions to local anesthetic?	☐ Yes	☐ No
Please describe:		
Do your gums bleed?	☐ Yes	☐ No
Is your mouth dry?	☐ Yes	☐ No
Teeth sensitive to heat, cold, sweets, brushing, or flossing?	☐ Yes	☐ No
Have you noticed any bad tastes or bad breath?	☐ Yes	☐ No
Have you ever had periodontal (gum) treatments?	☐ Yes	☐ No
Have you had orthodontic (braces) treatment?	☐ Yes	☐ No
Does food tend to become caught between your teeth?	☐ Yes	☐ No
Have you had any problems associated with previous dental treatment?	☐ Yes	☐ No
Do you have earaches or neck pains?	☐ Yes	☐ No
Do you have any clicking, popping or discomfort in the jaw?	☐ Yes	☐ No
Have you noticed any loose or shifting teeth?	☐ Yes	☐ No
Have any of your family members had significant dental treatment or tooth loss?	☐ Yes	☐ No
Would you be concerned if you lost your teeth and had to wear false teeth?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Have you had headaches on a regular basis in the morning, evening, or after eating?	☐ Yes	☐ No
Have you had your bite adjusted?	☐ Yes	☐ No
Do you have sores or ulcers in your mouth?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
Have you ever had a serious injury to your head or mouth?	☐ Yes	☐ No
Do you participate in active recreational activities?	☐ Yes	☐ No

Health History

Please rate your current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical exam Are you now under the care of a physician? ☐ Yes ☐ No

Current Physician

What condition is being treated?

Physician Name Phone Number

Address City State Zip

For Women

Are you pregnant? ☐ Yes ☐ No How many weeks?

Taking birth control pills or hormonal replacement? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No

What was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No

Please list any medications (prescription or over the counter) you are taking:

Name		For what condition?		Dosage	
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Name		For what condition?		Dosage	
Name		For what condition?		Dosage	

Do you need antibiotics prior to receiving dental care? ☐ Yes ☐ No Reason:

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No

Date: Have you had any complications?

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No Date treatment began:

Do you use controlled substances (drugs)? ☐ Yes ☐ No

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No How much do you typically drink in a week?

Allergies

Are you allergic to or have you had a reaction to:

Local anesthetics	☐ Yes	☐ No	Details:
Aspirin	☐ Yes	☐ No	Details:
Penicillin or other antibiotics	☐ Yes	☐ No	Details:
Barbiturates, sedatives, or sleeping pills	☐ Yes	☐ No	Details:
Sulfa drugs	☐ Yes	☐ No	Details:
Codeine or other narcotics	☐ Yes	☐ No	Details:
Metals	☐ Yes	☐ No	Details:
Latex (rubber)	☐ Yes	☐ No	Details:
Iodine	☐ Yes	☐ No	Details:
Hay fever/seasonal	☐ Yes	☐ No	Details:
Animals	☐ Yes	☐ No	Details:
Food	☐ Yes	☐ No	Details:

Other

Medical Conditions

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

AIDS / HIV Positive	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Anaphylaxia	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Radiation treatment	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Renal Disease	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Heart Pace Maker	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Hives / Rash	☐ Yes	☐ No	Tonsilitis	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Tumors/ Growths	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No			

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ Yes ☐ No

Please explain:

Confirmation

I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature _____