JEFFREY A. BRACKETT, D.M.D.
Specialist in Periodontics

PATIENT GENERAL INFORMATION

NAME | DATE

MAILING ADDRESS | CITY | ZIP | TELEPHONE - HOME

STREET ADDRESS | CITY | ZIP | TELEPHONE - BUSINESS

EMPLOYER | CITY | DATE OF BIRTH

OCCUPATION | MARITAL STATUS

SPOUSE'S NAME | SPOUSE'S EMPLOYER | SPOUSE'S OCCUPATION

PHYSICIAN | PHYSICIAN'S PHONE NO. | DATE OF LAST PHYSICAL EXAM

DENTIST | HOW LONG? | DATE OF LAST DENTAL EXAM | REFERRED BY

EMERGENCY CONTACT | PHONE NUMBER | PATIENT SOC. SEC. NUMBER

DENTAL INSURANCE COMPANY | INS. CERTIFICATE NUMBER | INS. GROUP NUMBER | SOC. SEC. NUMBER OF INSURED

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CHIEF DENTAL CONCERN

PATIENT DENTAL HISTORY	Yes	No
1. Are you having pain or discomfort at this time? Describe		
2. Have you a history of a. Pain in or near your ears?		
b. Unhealed injuries or inflamed areas in or around your mouth?		
c. Sensitive gag reflex?		
d. Pain in any part of your mouth when you clench your teeth?		
e. Trench Mouth?		
f. Bleeding gums?		
g Soreness in your mouth from cold? Hot? Sweets? Where?		
h. Headaches?		
3. Do you have any problems chewing?		
4. Do you have any jaw pain and/or numbness?		
5. Do you clench your teeth during the day or night?		
6. When were your teeth last cleaned?		
7. Have you ever had periodontal (gum) treatment?		
8. Do you have a family history of periodontal disease?		
9. Have you ever experienced complications or illness following dental treatment? Describe		
10. Do you feel nervous about having periodontal treatment?		
11. Have you ever had a bad experience in a Dental office?		
12. Has a physician ever instructed you to take antibiotics before dental treatment?		
13. Do you take an antibiotic on a regular basis?		
14. Has a dentist or hygienist shown you how to clean your teeth?		

15. Please check any items you use in mouth care

Hand Toothbrush _______ Toothpicks _______ Electric Toothbrush _______
Dental Floss _______ Stimudents _______ Other ________________________
Water Spray Device _______ Gum Stimulator _______

Remarks

I intend to pay for my Dental Treatment by:

☐ Cash/Check each visit ☐ Dental Insurance
☐ Credit Card each visit: ☐ VISA ☐ MasterCard
☐ Credit Card # ______________________ Exp. Date. ______________________ Signature ______________________
☐ Request Alternative Financial Arrangements/Care Credit

PLEASE COMPLETE REVERSE SIDE

FORM 084441 N/04/04 ITEM 8101 COLWELL SYSTEMS 1.800.637.1140

PATIENT MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD:

(PLEASE CIRCLE)	YES	NO	?
HEPATITIS: JAUNDICE OR LIVER DISEASE			
EPILEPSY CONVULSIONS OR FAINTING SPELLS			
RHEUMATIC FEVER			
RHEUMATIC HEART DISEASE			
HEART MURMUR			
MITRAL VALVE PROLAPSE			
HEART TROUBLE OR STROKE			
HIGH OR LOW BLOOD PRESSURE			
SHORTNESS OF BREATH ON MILD EXERTION			
CHEST PAIN ON MILD EXERTION			
PACEMAKER			
SWELLING IN ANKLES			
TUBERCULOSIS			
NIGHT SWEATS			
KIDNEY DISEASE OR INFECTION			
LIVER DISEASE			
DIABETES			
A ANY BLOOD RELATIVES			
B DO YOU URINATE FREQUENTLY			
C ARE YOU OFTEN THIRSTY			
ARTHRITIS OR RHEUMATISM			
STOMACH OR DUODENAL ULCERS			
MEDICAL RADIATION TREATMENT			
GLAUCOMA			
ASTHMA, HAY FEVER OR ALLERGIES			
SINUS TROUBLE			
EMPHYSEMA/RESPIRATORY DISEASE			
THYROID OR PARATHYROID DISEASES			
ARTERIOSCLEROSIS			
LATEX ALLERGY			
DRUG REACTION TO ______________________________			
SEXUALLY TRANSMITTED DISEASE			
HOSPITALIZATION FOR ILLNESS OR SURGERY			
HIVES OR SKIN RASH			
IMPLANT PROSTHESIS			
SOCIAL DRUG USE			

	YES	NO	?
A TUMOR OR ABNORMAL GROWTH			
ANEMIA OR BLOOD DISORDERS			
ABNORMAL BLEEDING PROBLEMS			
ANTICOAGULANTS (BLOOD THINNERS)			
BLOOD TRANSFUSION			
EMOTIONAL PROBLEMS OR TENSION			
NERVOUS BREAKDOWN OR PSYCHOTHERAPY			
PROSTATE TROUBLE			
ALCOHOLISM			
ANY SERIOUS ILLNESS NOT LISTED			
HAVE YOU EVER BEEN REFUSED AS A BLOOD DONOR?			
HIV DISEASE			
ARE YOU:			
PRESENTLY BEING TREATED FOR ANY ILLNESS			
TAKING ANY MEDICATION NOW (LIST BELOW) OR WITHIN THE PAST YEAR			
ALLERGIC TO DENTAL ANESTHETIC			
*ALLERGIC TO ANY MEDICATIONS OR MATERIALS			
AWARE OF RECENT WEIGHT GAIN OR LOSS			
OFTEN EXHAUSTED OR FATIGUED			
SUBJECT TO FREQUENT HEADACHES			
A NERVOUS PERSON			
TAKING NERVE OR SLEEPING MEDICATION			
OFTEN UNHAPPY OR DEPRESSED			
TAKING ANTIDEPRESSION MEDICATION			
DO YOU BRUISE EASILY			
DO YOU WEAR CONTACT LENSES			
ANY CHANGE IN YOUR HEALTH IN THE PAST YEAR			
ARE YOU UNDER THE CARE OF A PHYSICIAN NOW			
DO YOU CHEW TOBACCO			
HAVE YOU SMOKED IN THE PAST? HOW MUCH __________			

IF FEMALE, ARE YOU NOW (PLEASE CHECK IF YES)

PREGNANT _____ NURSING _____

ORAL CONTRACEPTIVE _____

ARE YOU TAKING ANTI-PREGNANCY DRUG _____

PRESENTLY IN MENOPAUSE ______ POST MENOPAUSE ______

DO YOU HAVE PROBLEMS WITH YOUR MENSTRUAL CYCLE _____

DO YOU HAVE OR HAVE YOU EVER HAD A EATING DISORDER _____

MEDICAL HISTORY NOTES (Office Use)

CURRENT MEDICATIONS

REMARKS

SIGNATURE OF PATIENT ______________________ DATE ______________

SIGNATURE OF DENTIST ______________________ DATE ______________