Denise M. Shapiro DDS, MA • Danika J. Crabtree DMD, MS
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 ______________________

Spouse employed by ______________ Occupation ______________ Spouse D.O.B ______________
Patient referred by ______________ Dental Insurance Coverage, if any______________
Name of closest non-relative to reach in case of emergency______________ Phone #______________

HEALTH HISTORY

Name of Physician ______________________ City ______________
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		
						Thyroid		
Stroke			Clotting Problems			High Cholesterol		
Diabetes			Glaucoma or Loss of Vision			Have you taken bisphosphonates? (Fosamax, Boniva, etc.)		
High or Low Blood Pressure			Epilepsy or Fainting spells					
Liver or Kidney Disorders			Nervous Disorders			Other-*please explain*		
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? ______
Have you ever tested positive (+) for HIV or Hepatitis C? ___

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: ______________________