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A Professional Corporation

PERIODONTICS • DENTAL IMPLANTS

GENERAL HEALTH

CIRCLE ONE

What is your estimation of your general health? GOOD _____ FAIR _____ POOR _____

- Yes No Are you now under the regular care of a physician?
If so, for what? _____
When was your last physical examination? _____
- Yes No Have you had any major operations, hospitalizations, or illnesses?
If so, for what? _____
- Yes No Are you taking any pills, medications or drugs?
If so, please list. _____
- Yes No Have you had any unusual reaction or allergies to any drugs, pill, medication or food?
If so, please list. _____
- Yes No Do you smoke?
- Yes No Do you drink alcohol?
- Yes No Are you on a diet of any kind?
- Yes No Are you excessively nervous or depressed?
- Yes No Have you ever been treated for nervous or mental disorders
- Yes No Do you find it necessary to sleep using two pillows
- Yes No Have you recently gained or lost excessive amounts of weight?
- Yes No Have you had abnormal bleeding after a cut or tooth extraction?

Do you have or have you ever had: **(PLEASE CHECK)**

- | | |
|--|---|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Kidney or bladder trouble |
| <input type="checkbox"/> Heart murmur (Mitral Valve Prolapse) | <input type="checkbox"/> High or low blood pressure |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Thyroid or parathyroid disease |
| <input type="checkbox"/> Arteriosclerosis or other heart problems | <input type="checkbox"/> Asthma or difficult breathing |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia or other blood disorders |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Frequent vomiting or diarrhea |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Arthritis or rheumatism |
| <input type="checkbox"/> Tumors or growths | <input type="checkbox"/> Painful or swollen joints / Artificial joints |
| <input type="checkbox"/> X-ray or radiation therapy | <input type="checkbox"/> Dizziness or lightheadedness |
| <input type="checkbox"/> Problems in healing | <input type="checkbox"/> Rashes or skin disorders |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Epilepsy, seizures, convulsions, fainting spells |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> AIDS (HIV) |
| <input type="checkbox"/> Hepatitis, jaundice or other liver disease | <input type="checkbox"/> Shortness of breath or chest pains upon exertion |
| <input type="checkbox"/> Tuberculosis, emphysema or other lung disease | <input type="checkbox"/> Swelling of the hands, feet or eyes |
| <input type="checkbox"/> Sexually related diseases | <input type="checkbox"/> Frequent fractures or dislocation |
| <input type="checkbox"/> Condition requiring Cortisone or other steroids | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Painful or frequent urination | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Ulcers (Stomach or Duodenal) | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Other conditions or diseases not listed _____ | |

(OVER)

Have you ever had a reaction to any of the following: **(PLEASE CHECK)**

Penicillin
 Sulfa drugs
 Codeine
 Aspirin

Erythromycin
 Tetracycline
 Dental anesthetic (Novocaine)
 Nitrous Oxide (Laughing Gas)

WOMEN ONLY: CIRCLE ONE

YES NO Are you pregnant?
YES NO Are you taking birth control pills
YES NO Have you reached menopause (Change of Life?)

DENTAL HEALTH

YES NO Are you dissatisfied with the appearance of your teeth?
YES NO Have you noticed any loosening of your teeth?
YES NO Does food tend to become caught between your teeth?
YES NO Do you suffer from pain and / or swelling of your gums?
YES NO Do your gums often bleed when you brush your teeth?
YES NO Do you have an unpleasant odor or taste in your mouth?
YES NO Do you ever have any soreness, pain, clicking or popping in the area in front of your ears?

Have you ever had::
 Orthodontic treatment (Braces)
 Oral Surgery (Extractions, etc.)
 Periodontal treatment
 Your teeth ground or bite adjusted

Do You:
 Clench or grind your teeth while awake or asleep
 Breathe primarily through your mouth

How often do you see your dentist? _____ When did you last have your teeth cleaned? _____
How often and when do you brush your teeth? _____ How long before that? _____
Do you use: Hand toothbrush () Electric toothbrush () Soft () Medium () Hard ()
What else do you use to clean your teeth? (floss, toothpick, waterpick, etc.) How often? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

CONSENT FOR TREATMENT

- I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
- Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor and to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- Lastly, I agree to be responsible for payment of all service rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements are made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% / month late charge (18% APR) may be added to my account.

Patient/Guardian Signature _____ Date _____
Doctor Signature _____ Date _____