



Peter A. Russo, D.D.S., Inc.
 Periodontics and Implant Surgery

Name _____ Marital Status _____ Sex _____ Date of Birth _____

Email _____
 Home Phone _____
 Work Phone _____

Address _____
 Street City Zip

Dentist _____ How Long? _____
 Name Address

Physician _____
 Name Address Phone

Referred By: _____ Reason: _____

Employed By: _____ Occupation: _____

Send Bill To: _____

GENERAL HEALTH

- | | YES | NO |
|---|------------|-----------|
| 1. Are you now and have you always been in good health ? | _____ | _____ |
| 2. Local anesthetics (novocaine, etc.) can have interactions with prescription medications, over the counter medications, and even "street drugs". Are you taking ANY drugs or medications ?..... | _____ | _____ |
| 3. Have you been under the care of a Physician over the past five years ? | _____ | _____ |
| 4. Do you have any allergies- especially to any drugs or medications ? | _____ | _____ |
| (e.g. penicillin, codeine, etc.) _____ | | |
| 5. Have you ever had an operation? | _____ | _____ |
| 6. Can you take aspirin ? | _____ | _____ |
| 7. Have you recently gained or lost an excessive amount of weight ?..... | _____ | _____ |
| 8. Are you in a high risk group for HIV ?..... | _____ | _____ |
| 9. Are you on a special diet ?..... | _____ | _____ |
| 10. Do you smoke ? | _____ | _____ |
| 11. Females only: Are you pregnant ? | _____ | _____ |
| Have you ever been ? | _____ | _____ |
| Have you ever had complications ?..... | _____ | _____ |
| Are you after menopause ?..... | _____ | _____ |
| Are you currently taking an oral contraceptive ? | _____ | _____ |

12. When was your last physical examination ? _____ Date: _____

GENERAL HEALTH

Have you ever had or currently have any of the following conditions? Please check appropriate box.

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Disease
<input type="checkbox"/> Angina
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Artificial Heart Valve
<input type="checkbox"/> Stroke
<input type="checkbox"/> Swelling of Hands, Feet, Eyes
<input type="checkbox"/> Difficult Breathing
<input type="checkbox"/> Asthma
<input type="checkbox"/> Anemia
<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Heart Surgery
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Rheumatism or Arthritis
<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease
<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Hay Fever / Frequent Sinus Infections
<input type="checkbox"/> Taken Cortisone or Steroids
<input type="checkbox"/> Epilepsy, Convulsions or Seizures
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Emphysema or other Lung Disorder
<input type="checkbox"/> Recent Cold / Flu
<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Artificial Joint or Prosthesis
<input type="checkbox"/> Glaucoma | <input type="checkbox"/> Frequent Vomiting or Diarrhea
<input type="checkbox"/> Rashes or Skin Disorder
<input type="checkbox"/> Excessive Nervousness
<input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> Tumor or Cancer
<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Frequent Cold Sores
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> HIV+
<input type="checkbox"/> AIDS or AIDS-related Complex
<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Any other not listed ?
_____ |
|---|--|--|

GINGIVAL HEALTH

- | | YES | NO |
|---|-------|-------|
| 1. Do your gums bleed now or did your gums bleed before? | _____ | _____ |
| 2. Have you ever had a gingival abscess (gum boil)? | _____ | _____ |
| 3. Do your gums often swell or become tender?..... | _____ | _____ |
| 4. Are any of your teeth loose? | _____ | _____ |
| 5. Do you have an unpleasant mouth odor or taste? | _____ | _____ |
| 6. Have you ever experienced an unfavorable reaction from dental treatment?..... | _____ | _____ |
| 7. Are you missing any teeth? | _____ | _____ |
| 8. | | |
| Reason: ___ Decay ___ Gum Disease ___ Other | | |
| 8. Do you clench or grind your teeth?..... | _____ | _____ |
| 9. Have you ever had gum treatment? | _____ | _____ |
| 10. When did you last have your teeth cleaned? _____ How long before that ? _____ | | |
| 11. How often do you brush your teeth ? _____ Hand ___ Electric ___ | | |
| 12. Have you ever had orthodontic (braces) treatment ? | _____ | _____ |

DENTAL INSURANCE

Primary Insurance Co. _____ Self ___ Spouse ___
 SSN of Insured _____
 Secondary Insurance Co. _____
 Name of Insured _____ SSN _____ DOB _____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have a change in health or medications I will inform you at my next appointment.

Signature of patient, parent or guardian _____ Date _____