Thomas B. Braun, D.D.S., M.S. Practice Limited to Periodontics
2312 Plainfield Rd. Crest Hill, Illinois 60403 (815) 744-7175

Dental History Questionnaire

_____ _____ _____
Last **First** **Middle**

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time?..... Yes ◯ No ◯
2. How may we help you?

3. What condition would you like your oral health to be in ten years from now?

4. Date of last dental visit? _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes ◯ No ◯

Do you have or have you ever had any of the following:

Bleeding, sore gums?	Yes ◯	No ◯	Shifting in bite?	Yes ◯	No ◯
Unpleasant taste/bad breath?	Yes ◯	No ◯	Change in bite?	Yes ◯	No ◯
Swelling/lumps in mouth?	Yes ◯	No ◯	Burning tongue/lips?	Yes ◯	No ◯
Orthodontic treatment (braces?)	Yes ◯	No ◯	Frequent blister, lips/mouth?	Yes ◯	No ◯
Clenching/grinding?	Yes ◯	No ◯	Sensitive teeth (hot or cold?)	Yes ◯	No ◯
When _____			Sensitive to sweets?	Yes ◯	No ◯
Clicking/popping jaw?	Yes ◯	No ◯	Sensitive to biting?	Yes ◯	No ◯
Difficulty opening or closing jaw?	Yes ◯	No ◯	Food Impaction?	Yes ◯	No ◯
Loose teeth?	Yes ◯	No ◯	Biting cheeks/lips?	Yes ◯	No ◯

Do you use the following?

Toothbrush Yes ◯ No ◯ How Often _____ Proxabrush? Yes ◯ No ◯
Toothbrush type is: ◯ Soft ◯ Medium ◯ Hard
Dental Floss? Yes ◯ No ◯ How Often_____
Does dental treatment make you nervous? Yes ◯ No ◯ Slightly ◯ Moderately ◯ Extremely ◯
If so what:
Etc:

Circle one:

1. Please evaluate the importance of your teeth: (1-10, 10 being highest) ____
2. What level of health do you think your current oral health is in? (1-10, 10 being highest) ____
3. Is there anything about your teeth you would like to change? If so please list.

4. Please rank the following options in the order in which they would prevent you from having dental treatment. (1-4, 1 being the highest) Fear of pain ____ Lack of concern ____ Cost of treatment____ Missing work time ____
5. Have you had any positive dental experiences?

6. Have you had any negative dental experiences?

7. Is there anything you would like to know about our office?

Thomas B. Braun, D.D.S., M.S., P.C. (Periodontal & Implant Dentistry)
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Medical History Form

Referred By_____ **Date** _____

Patient E-mail address: _____ **Home Phone**_____

Name _____ **Cell Phone** _____
Last First Middle

Address_____ **Business Phone** _____

City _____ **State** _____ **Zip Code**_____

Employer_____ **Job Title**_____ **SS#**_____

Date of Birth _____ **Sex** M ◯ F ◯ **Height**_____ **Weight**_____

Name of Spouse _____ **Closest Relative**_____ **Phone** :_____

If you are completing this form for another person, your relationship to that person is?_____

Your answers to the following questions are for our records only and are considered confidential. You may be questioned during your visit on your response to the questions you answered.

1. Are you in Good health?..... Yes ◯ No ◯
2. Have there been changes in your general health in the past year?..... Yes ◯ No ◯
3. Physician:
   Name: Address:
4. Last Physical Exam _____ Did you have blood drawn at this physical? Yes ◯ No ◯
5. Are you now under the care of your physician? Yes ◯ No ◯
   If so what is the condition being treated?

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes ◯ No ◯
   Please explain:

7. List any medications – prescription or non-prescription that you are currently taking:

8. Are you on Aspirin Therapy?..... Yes ◯ No ◯
9. Are you on Vitamin E Therapy?..... Yes ◯ No ◯
10. Have you taken or are you taking Bisphosphonates (Fosamax, Actonel, Boniva, Didronel)? Yes ◯ No ◯
    Please list which one & how long you've been taking:

11. Do you smoke?..... Yes ◯ No ◯
    If yes, how long have you smoked? _____ How many packs per day? _____
12. Do you have a family history of periodontal disease?..... Yes ◯ No ◯

Do you have or had any of the following diseases or problems:

1. Damaged or artificial heart valves?..... Yes ◯ No ◯
2. Heart murmur or rheumatic heart disease?..... Yes ◯ No ◯
3. Cardiovascular disease (heart trouble, heart attack, angina, coronary, insufficiency, coronary occlusion, stroke or arteriosclerosis?..... Yes ◯ No ◯
4. High Blood Pressure?..... Yes ◯ No ◯
5. Chest pain upon exertion?..... Yes ◯ No ◯
6. Shortness of breath after mild exercise or when lying down?..... Yes ◯ No ◯
7. Do you have inborn heart defects?..... Yes ◯ No ◯
8. Cardiac pacemaker?..... Yes ◯ No ◯
9. Seasonal Allergies?..... Yes ◯ No ◯
10. Sinus trouble?..... Yes ◯ No ◯
11. Asthma or hay fever?..... Yes ◯ No ◯
12. Fainting or seizures?..... Yes ◯ No ◯
13. Persistent diarrhea or weight loss?..... Yes ◯ No ◯

14. Diabetes Yes ◯ No ◯ Controlled? Yes ◯ No ◯ Blood Sugar Level: _____ Date: _____
15. Hepatitis, Jaundice, or liver disease?..... Yes ◯ No ◯
16. Aids or HIV infection?..... Yes ◯ No ◯
17. Thyroid problems?..... Yes ◯ No ◯
18. Respiratory problems, emphysema, bronchitis etc?..... Yes ◯ No ◯
19. Arthritis or painful swollen joints?..... Yes ◯ No ◯
20. Stomach ulcer or hyperacidity?..... Yes ◯ No ◯
21. Kidney trouble?..... Yes ◯ No ◯
22. Tuberculosis?..... Yes ◯ No ◯
23. Persistent cough, cough that produces blood or persistent swollen glands in neck? ..... Yes ◯ No ◯
24. Low blood pressure?..... Yes ◯ No ◯
25. Sexually transmitted disease?..... Yes ◯ No ◯
26. Epilepsy?..... Yes ◯ No ◯
27. Problems with mental health?..... Yes ◯ No ◯
28. Cancer?..... Yes ◯ No ◯
    What Type? _____ Treatment Received? _____
29. Problems of the immune system?..... Yes ◯ No ◯
30. Abnormal bleeding?..... Yes ◯ No ◯
31. Blood transfusion?..... Yes ◯ No ◯
32. Blood disorder such as anemia?..... Yes ◯ No ◯
33. Any treatment for tumor or growth?..... Yes ◯ No ◯

Are you allergic or have you had a reaction to:

1. Latex Allergy?..... Yes ◯ No ◯
2. Local anesthetic?..... Yes ◯ No ◯
3. Penicillin or other antibiotics?..... Yes ◯ No ◯
4. Sulfa drugs?..... Yes ◯ No ◯
5. Barbiturates, sedatives, or sleeping pills?..... Yes ◯ No ◯
6. Aspirin?..... Yes ◯ No ◯
7. Iodine?..... Yes ◯ No ◯
8. Codeine or other narcotics?..... Yes ◯ No ◯
9. Other?

General Information

1. Do you have any disease, conditions, or problems not listed you think I should know about? Yes ◯ No ◯
   Explain:

2. Are you wearing contact lenses?..... Yes ◯ No ◯
3. Are you wearing removable dental appliances?..... Yes ◯ No ◯

Women

1. Are you pregnant?..... Yes ◯ No ◯
2. Are you nursing?..... Yes ◯ No ◯
3. Are you taking birth control pills?..... Yes ◯ No ◯

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient

For completion by dentist:

Comments on patient interview concerning medical history

_____

Date: _____ Signature of Dentist:_____

Pharmacy Name:_____ Pharmacy Phone: _____

DENTAL INSURANCE

Primary Company_____ **Group** _____

I.D. Number from Insurance card (Required) _____
(if your insurance card has no ID number listed; enter your social security number)

Insurance Address_____

Insurance Phone # _____

Subscriber _____

Relationship to patient _____ Date of Birth ____/____/_____

Subscriber's Employer _____

Employer's Address _____

Employer's Phone # _____

MEDICAL INSURANCE

Primary Company_____ Group #_____

Insurance Phone # _____

Insurance Address_____

Relationship to patient_____ I.D. Number (required) _____

Subscriber_____ Date of Birth ____/____/_____

Your signature is necessary for us to process all insurance claims, to ensure payment for services rendered, and to release medical information to other providers, when necessary, for treatment.

I authorize the release of certain protected health information (PHI) about me when necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical\dental care. I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Thomas B. Braun. This assignment will remain in effect until revoked by me in writing or expire on date of completed treatment. A photocopy of this assignment is to be considered as valid as the original.
By signing this form you hereby accept responsibility to pay your estimated insurance co-payment at the time of service.

X Signature of Patient_____**Date**_____
Parent or legal guardian