PHC
PERIODONTAL
HEALTH CENTER

Dr. Steven Lieber, DDS
Dr. Jessica Stilley, DMD, MS

Patient Information

Last Name: _____ First Name: _____ Middle:_____

Preferred Name: _____ Date of Birth: _____

Gender: Male Female Marital Status:_____ Social Security #: _____

Driver's License #: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Primary Phone Number: _____ Alternate Number: _____

Occupation: _____ Employer: _____

General Dentist: _____ Referred by: _____

Dental Plan Information

PLEASE NOTE: The below dental information must be fully completed in order for your claims to be filed as a courtesy to you. We will need a copy of your Insurance card. We are the third party.

Dental Plan: _____ Group #: _____

Address: _____ City: _____

State: _____ Zip: _____

Name of Employer: _____ Work Phone: _____

Name of Insured: _____ Relationship to patient: _____

Social Security # _____ Birthdate: _____

Subscriber ID: _____

If you have secondary dental coverage please complete the information below.

Dental Plan: _____ Group #:_____

Address: _____ City: _____

State: _____ Zip: _____

Name of Employer: _____ Work Phone: _____

Name of Insured: _____ Relationship to patient: _____

Social Security #: _____ Birthdate: _____

Subscriber ID: _____

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Dr. Jennifer Fiorica, DMD, MSD

Dental Health Questionnaire

Patient Name: _____

Preferred Name: _____

Please answer the following questions honestly. Your answers will be kept strictly confidential and will be used to help provide you with the very best care.

1. Are you having any discomfort in your mouth at this time? YES NO
2. What is your main dental concern _____
3. When was your last dental visit? _____
4. Does dental treatment make you nervous? YES NO
5. Have you had a bad dental experience? YES NO
6. Have you ever had nitrous, oral/IV sedation for dental treatment? YES NO
7. On a scale of 1-10, 10 being the highest, how important are your teeth?_____
8. On a scale of 1-10, 10 being the highest, how important is your oral health?_____
9. How often do you have your teeth professionally cleaned? _____
10. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?
    YES NO
11. Do you currently use any of the following? (check all that apply)
    - ☐ Toothbrush
    - ☐ Dental Floss
    - ☐ Proxybrush
    - ☐ Water/Air Flosser
    - ☐ Toothpicks
    - ☐ Toothpaste
    - ☐ Mouth rinse
12. Do you have any of the following? (check all that apply)
    - ☐ Bleeding of the gums
    - ☐ Swelling/lumps in the mouth
    - ☐ Sensitivity to hot or cold
    - ☐ Bad Breath/unpleasant taste
    - ☐ Loose teeth
    - ☐ Difficulty opening/closing/chewing
    - ☐ Clenching/grinding teeth
    - ☐ Clicking or pain in the jaws
    - ☐ Head/neck/jaw trauma
13. Is there anything you don't like about your smile?

    _____

    _____
14. Is there anything preventing you from receiving the appropriate dental treatment? Please explain:

    _____

    _____

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Medical Health Questionnaire

Your answers to the following questions are for our records only and will be kept strictly confidential. You may be asked further questions about your responses at your dental visit.

1. Are you in good health YES NO
2. Have there been any changes to your health in the past year? YES NO
3. Who is your family physician? _____
4. When was your last physical exam? _____
5. Are you currently being treated for a medical condition? YES NO
    1. If yes, which condition? _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Please explain:

    _____

    _____
7. Please fill in the following:

Medication	Dose/Frequency	Condition

8. Are you on aspirin therapy? YES NO
9. Do you take Coumadin, Eliquis, Pradaxa, Plavix? YES NO
10. Do you take Vitamin E, or Fish Oil? YES NO
11. Have you taken or do you take Bisphosphonates (Fosamax, Actonel, Boniva, Reclast)?
    1. If yes, which one and for how long? _____

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12. Do you smoke? YES NO
    1. If yes, what do you smoke? _____
    2. How much do you smoke per day? _____
    3. For how many years have you smoked? _____
    4. Have you ever quit? _____
    5. Would you like to quit? _____
13. Do you drink alcohol? YES NO
14. Do you use marijuana, cocaine, or other drugs? YES NO
15. Do you have a family history of periodontal disease? YES NO
    1. If yes, who in your family is/was affected? _____
16. Do you have any of the following? (check all that apply)

- ☐ Damaged/Artificial heart valves
- ☐ History of infective endocarditis
- ☐ Congenital heart defects
- ☐ Heart transplant
- ☐ Cardiovascular Disease (heart trouble, heart attack, angina, coronary insufficiency/ occlusion, stroke, arteriosclerosis)
- ☐ Irregular heart beat/pacemaker
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Sinus trouble
- ☐ Asthma
- ☐ Respiratory problems/emphysema/COPD
- ☐ Joint replacement
- ☐ Fainting/seizure/epilepsy
- ☐ Sleep apnea
- ☐ Hepatitis/jaundice/liver disease
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ HIV/AIDS/immunocompromised disease
- ☐ Thyroid problems
- ☐ Arthritis/painful or swollen joints
- ☐ Stomach ulcer/GERD
- ☐ Kidney problems
- ☐ Sexually transmitted disease
- ☐ Problems with mental health/dementia/ memory loss
- ☐ Cancer
- ☐ Bleeding disorder/excessive bleeding
- ☐ Difficulty hearing/hearing aids

16. Are you allergic or have you had a reaction to:

- ☐ Latex
- ☐ Local anesthetic
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates/sedatives/sleeping pills
- ☐ Aspirin
- ☐ Iodine
- ☐ Codeine/narcotics
- ☐ Other: _____

17. Do you have any other disease, condition or problems not mentioned above? Please explain:

_____

_____

18. Women only, are you:

- ☐ Pregnant
- ☐ Nursing
- ☐ Taking Birth Control Pills