East End Periodontics & Dental Implants
●384 Montauk Hwy●Wainscott, NY 11975●631.537.1505●info@eastendperio.com

Date: ________________

Name: ____
Last First MI

Address: ____

City: ______________________________ State:_____________Zip: ____________

Telephone:
(Home): _________________ (Work): _______________ (Mobile): _______________

Which is the best way to contact you during daytime hours? (Circle): Home Work Mobile E-Mail Text

Email address: ____

Date of birth: ________________________ Age: ______ SSN: _____________________

Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other:______

Company Name & Address: ____

Occupation: ____

Referred By: ☐Family member or friend_____________________________ ☐ Magazine Article or TV Show___________________

☐ Other patient or Doctor______________________________ ☐ website ☐ other______________________

Person to contact in case of an emergency: ____

Relationship: ______________________________
Phone: ______________________________

Dental History

Date of last dental examination: ____________________

Date of last series of complete mouth x-rays: ______________________

1. Do your gums bleed while brushing or flossing? …………… Yes No
2. Are your teeth sensitive to hot or cold liquids/foods?........... Yes No
3. Are your teeth sensitive to sweet or sour liquids/foods?……. Yes No
4. Do you feel pain to any of your teeth?.............................. Yes No
5. Have you had any head, neck or jaw injuries?.................... Yes No

6. Have you ever experienced any of the following problems in your jaw:

a) Clicking? .... Yes No
b) Pain (joint, ear, side of face)? .... Yes No
c) Difficulty in opening or closing? .... Yes No
d) Difficulty in chewing? .... Yes No
7. Do you have frequent headaches? .... Yes No
8. Do you clench or grind your teeth? .... Yes No
9. Do you bite your lips or cheeks frequently? .... Yes No
10. Have you had orthodontic work? .... Yes No
11. Have you had prolonged bleeding following extractions? ...Yes No
12. Do you smoke cigarettes, cigars or pipes? .... Yes No
13. Would you like your teeth to look whiter?...................... Yes No
14. Would you like to change your smile? .... Yes No
15. Are you here for a specific reason? .... Yes No
Please explain ____

Have you ever been pre-medicated with antibiotics before any dental treatment? Yes No

Medical History

Date of last medical examination: ________________________

Physician: ________________________________
Office Phone: ______________________________
Have you ever had any of the following:

Diagnosed with Heart Murmur/Mitral Valve?	☐	Rheumatic Fever or Rheumatic Heart Disease?	☐
Heart Attack, angina, or other heart disease?	☐	Prosthetic or Artificial heart valve?	☐
Irregular heartbeat or pacemaker?	☐	Shortness of breath after mild exercise?	☐
High Blood Pressure?	☐	Swollen ankles?	☐
Asthma, emphysema, or difficulty breathing?	☐	Recent increase in thirst?	☐
Stroke, seizures, or convulsions?	☐	Stomach ulcers or stomach problems?	☐
Diabetes?	☐	AIDS, ARC, HIV infection?	☐
Recent increase in urination?	☐	Arthritis or rheumatism?	☐
Thyroid Problems?	☐	Prosthetic or Artificial joint?	☐
Kidney trouble or Renal Dialysis?	☐	Cancer, radiation treatment or chemotherapy?	☐
Hepatitis, liver disease, or jaundice?	☐	Venereal disease? Syphilis? Gonorrhea?	☐
Tuberculosis?	☐	Persistent cough or coughing up blood?	☐
Psychiatric treatment?	☐	Enlarged lymph nodes or swollen glands?	☐
Autoimmune disease or lupus erythematousus?	☐	Hearing problem or vision problems?	☐
Blood disorder, bleeding tendency or frequent bruising?	☐		

List ALL hospitalizations and serious illnesses, including dates:

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Do you have any allergies? Yes No If yes, what? ______________________________

Have you ever taken penicillin? Yes No

Have you ever had a bad reaction to any drug or medication? Yes No

If yes, what?
☐ Penicillin or other antibiotic ☐ Aspirin
☐ Dental anesthetic ☐ Codeine or other narcotics
☐ Other: ______________________

[WOMEN ONLY] Are you pregnant or think you may be pregnant? Yes No

List any and all medication(s) you are taking (including non-prescription):

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I understand and authorize Dr. Ancy Verdier, his associates and staff, to take all diagnostic materials needed to make a final diagnosis of dental treatment. Diagnostic materials may include intra-oral pictures, radiographs, digital radiographs, diagnostic models, photographs and slides. This material may be used for lectures, articles or publications.

I authorize Dr. Ancy Verdier, his associates and staff, to perform and/or administer any and all forms of treatment, medication and anesthesia that may be necessary. I understand that the dental treatment presented to me is my financial responsibility and that all fees for services are due and payable up front and/or at the completion of treatment as authorized by Dr. Ancy Verdier and/or an administrator.

I will assume all responsibility of notifying Dr. Ancy Verdier, his associates and staff, of any changes in my medical history or contact information.

I certify that all of the information I have provided is accurate and truthful to the best of my knowledge.

Patient's Signature: ____

Date: __________________