deborahruprecht DDS
periodontics & implant specialty

PATIENT INFORMATION

Date _____ ☐Mr. ☐Mrs. ☐Ms. ☐Dr.

Patient's name _____ Date of birth _____

Home Address, City, ST, Zip _____

Email _____ Driver's license # _____ Social Security # ___ - ___ - ____

Phone 1 ( ) _____ ☐Mobile ☐Home ☐Work Phone 2 ( ) _____ ☐Mobile ☐Home ☐Work

General dentist _____ Dentist phone ( ) _____

Physician _____ Physician phone ( ) _____

Physician Address, City, ST, Zip _____

Employer _____ Pharmacy _____ Pharmacy phone ( ) _____

Emergency contact _____ Relationship _____ Phone ( ) _____

Reason for today's visit _____

Who referred you to our office? _____

DENTAL INSURANCE

Primary ☐Copy of insurance card

Insurance company

Address _____

Insurance phone ( ) _____

Name of insured _____

Relationship to patient _____

Social Security # ___ - ___ - ____ DOB _____

Employer _____ Ph ( ) _____

Group / Policy # _____

Subscriber ID # _____

Secondary ☐Copy of insurance card

Insurance company

Address _____

Insurance phone ( ) _____

Name of insured _____

Relationship to patient _____

Social Security # ___ - ___ - ____ DOB _____

Employer _____ Ph ( ) _____

Group / Policy # _____

Subscriber ID # _____

RESPONSIBLE PERSON IF OTHER THAN PATIENT

Responsible person _____ Employer _____

Relationship to patient ☐Spouse ☐Partner ☐Parent ☐Guardian ☐Other _____

Home Address, City, ST, Zip _____

Phone 1 ( ) _____ ☐Mobile ☐Home ☐Work Phone 2 ( ) _____ ☐Mobile ☐Home ☐Work

Email _____ Driver's license # _____ Social Security # ___ - ___ - ____

ASSIGNMENT AND RELEASE

I authorize and release any information necessary to process my or my dependent's claims and request payment or benefit paid directly to the doctor. I also agree that should the amount be insufficient to cover the entire expense, I will be responsible for the difference. I will also be responsible for all bank charges, office charges, and collection charges if incurred. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures, as may be necessary for proper dental care. The information on this page and the medical/dental histories are correct to the best of my knowledge. I grant the right to the dentist to release my medical/ dental histories and other information about my dental treatment to third party pay or and/or health professionals.

Signature _____ **Date** _____

Patient, parent or guardian

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HEALTH HISTORY

ASA I II III IV

To ensure your well-being while undergoing treatment in our office, please answer the following confidential questions in detail.

Patient's name

Do you consider yourself to be in good health?..... ☐Yes ☐No

If not, please describe: _____

Are you under the care of a physician? ☐Yes ☐No If so, why? _____

Were you hospitalized in the past 5 years? ☐Yes ☐No If so, why? _____

Have you ever had any of the following conditions?

CARDIOVASCULAR SYSTEM

High blood pressure……	☐Yes	☐No	
Congenital heart disease……	☐Yes	☐No	
Mitral valve prolapse……	☐Yes	☐No	
Rheumatic fever……	☐Yes	☐No	
Heart murmur……	☐Yes	☐No	
Heart pacemaker…… Date? _____	☐Yes	☐No	
Heart valve surgery…..... Date? _____	☐Yes	☐No	
Heart or bypass surgery… Date? _____	☐Yes	☐No	
Heart attack……..... Date? _____	☐Yes	☐No	
Congestive heart failure……..	☐Yes	☐No	
Angina pectoris / chest pain……	☐Yes	☐No	
Swollen ankles……..	☐Yes	☐No	
Irregular or rapid heartbeat……	☐Yes	☐No	
Stroke……	☐Yes	☐No	
High cholesterol……	☐Yes	☐No	

RESPIRATORY SYSTEM

Emphysema or asthma……	☐Yes	☐No
History of nose bleeds……	☐Yes	☐No
Chronic cough or bronchitis……	☐Yes	☐No
Chronic sinusitis……	☐Yes	☐No
Breathing problems……..	☐Yes	☐No

MUSCULO-SKELETAL / CNS / DEVELOPMENTAL

Frequent headaches……	☐Yes	☐No
Fainting spells or loss of consciousness……..	☐Yes	☐No
Seizures or epilepsy……	☐Yes	☐No
Visual impairment / Glaucoma…….....	☐Yes	☐No
Hearing impairment…….....	☐Yes	☐No
Artificial joint……	☐Yes	☐No
Arthritis or bone disease…….....	☐Yes	☐No
Muscle disease……..	☐Yes	☐No
Spinal cord injury or paralysis……..	☐Yes	☐No
Cerebral palsy…….....	☐Yes	☐No
Intellectual disability / Autism……..	☐Yes	☐No
Alzheimer's disease / Other dementia……	☐Yes	☐No

HEMATOLOGIC

Blood transfusion……..	☐Yes	☐No
Denied permission to donate blood…….....	☐Yes	☐No
Blood or bleeding disorders……	☐Yes	☐No
☐Anemia ☐Leukemia ☐Lymphoma……	☐	☐No
Hemophilia……..	☐Yes	☐No
Sickle cell disease……	☐Yes	☐No
Blood clots……..	☐Yes	☐No
Bleeding or bruising tendency……	☐Yes	☐No

ENDOCRINE

Diabetes ☐Type I ☐Type II……..	☐Yes	☐No
Insulin dependent?.....	☐Yes	☐No
Most recent Hemoglobin A1c……. Date? _____		
Frequency of HbA1c testing ☐3 mos ☐6 mos ☐12 mos		
Frequency of blood sugar testing ___x per day		
Thyroid disease……..	☐Yes	☐No
Adrenal gland disease……..	☐Yes	☐No
Osteoporosis……..	☐Yes	☐No

IMMUNE

Cancer / Radiotherapy / Chemotherapy……....	☐Yes	☐No
Systemic Lupus……..	☐Yes	☐No
Tuberculosis (TB)……..	☐Yes	☐No
AIDS……	☐Yes	☐No
HIV infection……..	☐Yes	☐No
Sudden weight loss / gain…….....	☐Yes	☐No
Frequent ☐Thirst ☐Hunger ☐Urination		☐No

GASTROINTESTINAL / GENITOURINARY

Colitis or ulcers……..	☐Yes	☐No
Hepatitis or other liver disease……..	☐Yes	☐No
Renal dialysis / transplant…….....	☐Yes	☐No
Kidney disease……..	☐Yes	☐No
Frequent canker sores……..	☐Yes	☐No
Frequent vomiting……..	☐Yes	☐No
Chronic diarrhea…….....	☐Yes	☐No

PSYCHIATRIC

Anxiety / Nervousness..... ☐Yes ☐No
Depression..... ☐Yes ☐No
Past / present psychiatric treatment..... ☐Yes ☐No

FAMILY HISTORY (Grandparents, siblings, children)

Diabetes..... ☐Yes ☐No
Heart disease..... ☐Yes ☐No
Bleeding disorders..... ☐Yes ☐No

DENTAL HISTORY

Pain or discomfort related to your mouth?..... ☐Yes ☐No
If yes – describe _____
Anxiety about dental treatment..... ☐Yes ☐No
Previous bad experience in a dental office..... ☐Yes ☐No
Periodontal surgery..... ☐Yes ☐No

FEMALES

Pregnancy..... Months? _____ ☐Yes ☐No
Anticipate becoming pregnant..... ☐Yes ☐No
Birth control..... ☐Yes ☐No
Nursing..... ☐Yes ☐No
Heavy menstrual bleeding..... ☐Yes ☐No

ALLERGIES / ADVERSE REACTIONS

Penicillin / Sulfa drugs..... ☐Yes ☐No
Novocain / Lidocaine..... ☐Yes ☐No
Dental anesthetics..... ☐Yes ☐No
Aspirin / Codeine..... ☐Yes ☐No
Latex products..... ☐Yes ☐No
Iodine..... ☐Yes ☐No
Other… ☐Yes – Describe _____ ☐No

SOCIAL HISTORY

Tobacco use ☐Current ☐Past..... ☐No
☐Cigarettes ☐Snuff/Chew ☐Cigars ☐Pipes
___x per ☐day ☐wk ☐mo ___ years of use
Vape use ☐Current ☐Past..... ☐No
If yes – type? _____
___x per ☐day ☐wk ☐mo ___ years of use
Alcohol use ☐Current ☐Past..... ☐No
If yes – type? _____
___x per ☐day ☐wk ☐mo ___ years of use
Marijuana use ☐Current ☐Past..... ☐No
___x per ☐day ☐wk ☐mo ___ years of use

PRESCRIPTION MEDICATIONS

Do you now take or have you taken any of the following medications?

Anticoagulants..... ☐Yes ☐No
Tranquilizers..... ☐Yes ☐No
Heart medication..... ☐Yes ☐No
Nitroglycerin..... ☐Yes ☐No
Antidepressants..... ☐Yes ☐No
Past or present recreational drugs..... ☐Yes ☐No
History of drug addiction..... ☐Yes ☐No

Cortisone..... ☐Yes ☐No
Blood pressure medication..... ☐Yes ☐No
Aspirin..... ☐Yes ☐No
Bisphosphonates ☐Yes – How long? ☐No
☐IV or ☐Oral..... ☐Fosamax ☐Actonel ☐Boniva
Past Bisphosphonates ☐Yes – Last use? _____ ☐No

Current medications _____

DIETARY SUPPLEMENTS

Do you take any of the following supplements?

☐Echinacea ☐Licorice ☐Ginseng ☐Ephedra / Ma Huang ☐Garlic / Ajo
☐St. John's Wort ☐Ginkgo ☐Valerian ☐Ginger ☐Feverfew
☐Coenzyme / Q10 ☐Goldenseal ☐Saw Palmetto _____ _____

Current supplements _____

Do you have any other conditions not already mentioned?..... ☐Yes ☐No

If yes – please describe _____

I understand that my doctor requests confidential health information to ensure my well-being while undergoing treatment. I have answered truly and correctly to the best of my knowledge.

Signature _____ **Date** _____
Patient, parent or guardian