

TIMBERLANE

DENTAL
GROUP PLC



EXCELLENCE IN FAMILY DENTISTRY

General Dentistry

Jeffrey Berkowitz, DDS
Gregory C. Chan, DDS
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Periodontics & Dental Implants

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PATIENT INFORMATION

Full Name _____ Soc. Sec. # _____ Date of Birth _____

Address _____ City _____ State/ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

My Physician's Name _____ E-mail Address _____ Male Female

Employer _____

How would you like to be addressed? Mr. Mrs. Ms. Dr. First Name or _____ Where should we confirm your appointment?

Home Cell

Who should we contact in case of emergency? Name _____

Relationship to patient _____ Emergency contact phone # _____

Are you allergic to any medications or substances? Please check box below.

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

Do you now have or have you ever had any of the following? Please check appropriate boxes.

***If yes to any of the starred conditions, please call prior to your appointment. Pre-medication may be required.**

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Leukemia | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Heart Murmur* (Presently) | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> X-ray Treatments (Radiation) | <input type="checkbox"/> Cortisone Medicine |
| <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Hemophilia (Bleeding Problem) | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Heart Surgery* | <input type="checkbox"/> Anemia | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Recent Blood Transfusion | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Renal Problems | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Asthma | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Allergies (Medicine) |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> |
| WOMEN: (Please check) | <input type="checkbox"/> Pregnant/trying to get pregnant | <input type="checkbox"/> Nursing | <input type="checkbox"/> Taking oral contraceptives |

Have you taken or are you taking medication known as **Bisphosphonate**: injectable form- Zometa, Aredia, Bonefos, Boniva; oral form- Fosamax, Didronel, Actonel, Skelid, Boniva, Ostac? Yes No

List Medications Taken: _____ Reason Taken: _____ Date started/will start taking this medication? _____

When was your most recent physical? _____

Have you ever had any other serious illness, operation or been hospitalized in the past 5 years? Discuss _____ Yes No

X _____ Date _____
Patient Signature (Parent or Guardian)

Reviewed by Doctor _____ Date _____

History Review and Significant Findings: _____

PLEASE COMPLETE OTHER SIDE

DENTAL HISTORY

Referred by _____

Date of your most recent dental exam? ____/____/____

Date of most recent x-rays? ____/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

PLEASE RATE THE CONDITION OF YOUR TEETH : Scale of 1 to 10 (excellent) _____

WHAT IS YOUR IMMEDIATE CONCERN? _____

PERSONAL HISTORY:

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____ Yes No
2. Have you had an unfavorable dental experience? _____ Yes No
3. Have you ever had complications from past dental treatment? _____ Yes No
4. Have you ever had trouble getting numb or reactions to local anesthetic? _____ Yes No
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ Yes No
6. Have you had any teeth removed? _____ Yes No
7. Do you wish to talk to the dentist privately about any problem? _____ Yes No

SMILE CHARACTERISTICS

8. Is there anything about the appearance of your teeth that you would like to change? _____ Yes No
9. Have you ever whitened (bleached) your teeth? _____ Yes No
10. Are you self conscious about your teeth? _____ Yes No
11. Have you been disappointed with the appearance of previous dental work? _____ Yes No

BITE AND JAW JOINT

12. Do you/would you have any problems chewing gum? _____ Yes No
13. Do you/would you have any problems chewing bagels or other hard foods? _____ Yes No
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ Yes No
15. Are your teeth crowding or developing spaces? _____ Yes No
16. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____ Yes No
17. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ Yes No
18. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ Yes No
19. Do you have tension headaches or sore teeth? _____ Yes No
20. Do you wear or have you ever worn a bite appliance? _____ Yes No

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ Yes No
22. Do you have a dry mouth? _____ Yes No
23. Are any teeth sensitive to hot, cold, biting or sweets? _____ Yes No
24. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____ Yes No
25. Do you avoid brushing any part of your mouth? _____ Yes No
26. Do you feel or notice any holes (i.e. pitting) in your teeth? _____ Yes No

GUM AND BONE

27. Have you ever been diagnosed or treated for periodontal (gum) disease? _____ Yes No
28. Have you ever experienced gum recession? _____ Yes No
29. Is there anyone with a history of periodontal disease in your family? _____ Yes No
30. Do your gums bleed when brushing, flossing or eating? _____ Yes No
31. Are your teeth becoming loose? _____ Yes No
32. Have you ever noticed an unpleasant taste or odor in your mouth? _____ Yes No
33. Have you experienced a burning sensation in your mouth? _____ Yes No