Gaston Berenguer, D.M.D., M.S.

Periodontics and Oral Implantology
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Dental Implants
Bone Grafting
Ridge Augmentation

Soft Tissue Grafting
Gum Disease
Oral & I.V. Sedation

Date: _________ Your Dentist: ___________________ Who told you about us? ____________________
Name: _______________________________ Date of Birth: _________________
Address: ____ (Street) __________ (City) _________ (State) ________ (Zip)

Phone: _____________ home E-mail _________________ Social Security #______________________
_______________ work Emerg. contact name and phone ____________________________________
_______________ cell/pg Employer name ____
Sex: M or F (circle) Height: _____ Weight: ______ Marital Status: ______ Spouse Name: _________________

Physician: ____________________________ Secondary Physician: _____________________________

Present Health

Please answer all the questions to the best of your ability. Please inform us of any changes in the future including new medications or changes in dosages. Your responses are only for our records and will be kept confidential.

Please circle appropriate answers, details should be described in comments section:

Are you under care of a physician? .... Yes No
Have you ever had any serious illness or operation (especially heart)? .... Yes No
Have you ever had radiation therapy, chemotherapy or have taken bisphosphanates? .... Yes No
Are you diagnosed with Osteoporosis or Osteopenia? .... Yes No
Are you allergic/sensitive to codeine, aspirin, sulfa, penicillin, novocaine, or any other drug? .... Yes No
Do you have any pain or impairment of your eyes, ears, nose, throat or neck? .... Yes No
Have you ever tested positive for Tuberculosis(TB), or the Hepatitis or HIV(AIDS) Viruses? .... Yes No
Do you take blood thinners such as Coumadin, Plavix, Pradaxa, Xarelto, Eliquis? .... Yes No
Females
Are you now pregnant, could be pregnant or are anticipating pregnancy? .... Yes No
Have you undergone or are you presently undergoing menopause? .... Yes No
Are you taking birth control medications? .... Yes No

Please indicate any illness or conditions you have had and year of the illness:

__Heart Disease	__Organ Transplant	__Use illegal drugs/addiction	__Herpes
__Heart Attack	__Heart Murmur	__Alcoholism	__Anemia
__Stroke	__Joint Replacement	__Epilepsy/Seizure	__Asthma
__High Blood Pressure	__Mitral Valve Prolapse	__Skin Condition	__Migraine
__Glaucoma	__Rheumatic Fever	__COPD/Shortness of breath	__TMJ
__Pacemaker	__Told to take antibiotics	__Eye Condition	__Anxiety
__Angina (chest pain)	__Hepatitis/Liver Disease	__Venereal Disease	__Mental
__Stents	__Bleed easy or can't stop	__Thyroid Disease	__Allergies
__Diabetes	__Bruise easy	__Tuberculosis	__Cancer
__Kidney Disease	__Take blood thinners	__Respiratory (lung)	__Osteoporosis/penia
__Indwelling Catheter	__Take Aspirin, Fish Oil, Vit E	__Sinus Trouble	__Arthritis

Comments ____

Intake

Have you ever smoked (including pipe, cigars)? Yes or No Currently? Yes or No
How many packs per day? ____________ How many years? _______Year you quit? _______
Do you use smokeless tobacco? Yes or No How many years? _______
What is your alcohol consumption per week? ___________
Please list all medications you are currently taking (prescription, over-the-counter, birth control pills, vitamins, etc.)____
____
____

Dental History

Do you have any of the following? Please indicate and add comments to the side or below.

__Bleeding gums
__Bad taste or odor in your mouth
__Clicking or pain when opening or closing your jaw
__Generalized or localized pain
__Sensitivity to cold or hot
__Grinding or Clenching

Have you had any of the following in the past?

__Gum boils or abscesses
__Braces
__Third molars (wisdom teeth) extractions
__Periodontal Disease (Pyorrhea)
__Periodontal treatment-non surgical (deep cleaning)
__Periodontal treatment-surgical
__TMJ treatment
__Bad experience in a dental office

What do you consider most important? (Rank 1-4)
__Preservation of natural teeth __Elimination of infection
__Elimination of pain __Appearance

Do you have any other disease or problem that we should know about? Please list below.
____

Comments____
____
____
____

I certify that I have provided accurate answers to the best of my knowledge and that I have not withheld any medical information or misled Dr. Gaston Berenguer in any way.

Signature: _________________________ Date: ________ Reviewed by: _________________________

Thank you for your cooperation!

GB 5/05