FREDRIC JAY WITKIN, D.D.S. **JORGE R. CENTURION, D.D.S.**

Welcome to our office. Your cooperation in answering the following questions will help us in evaluating your periodontal needs.

DATE	NAME	AGE	DATE OF BIRTH	SEX

Address
City Zip
Home Phone Cellular
Email
❐ Ok To Contact Via Email / Send Statements?
Occupation
Name Of Business & Address
City Zip
Business Phone
Referred By

Social Security #
FL Drivers License #
Marital Status: Single ❐ Married ❐ Divorced ❐
If Married, Spouse's Name
Spouse's Occupation
Name Of Spouse's Business & Address
Zip
Spouse's Business Phone

Do you have dental insurance? Yes ❐ No ❐
If yes, with what company? ______
Insurance Address ______
I authorize release of any information relating to insurance claims.
I understand that I am responsible for all costs of dental treatment.
Signature ______ Date ______

Policy # ______ Group # ______ PT. I.D. # ______
Name of policy holder ______
I hereby authorize payment directly to Drs. Witkin and Centurion benefits otherwise payable to me.
Signature ______ Date ______

NAME OF YOUR PHYSICIAN
PHYSICIAN'S PHONE #
PHYSICIAN'S ADDRESS ______
DATE OF LAST EXAM

MY GENERAL HEALTH IS: Excellent ❐ Good ❐ Fair ❐ Poor ❐	Yes	No
1. Are you now under the care of a physician? If yes, for what condition?		
2. Are you taking any medication regularly? If yes, what medication?		
3. Do you premedicate for dental procedures? If yes, what medication?		
4. Have you ever had an adverse reaction to medication? Penicillin ❐ Codine ❐ Aspirin ❐ Other, please specify ❐ ______		
5. Have you had a serious illness or operation? If yes, specify.		
6. Have you been hospitalized in the last 5 years? If yes, why?		
7. Do you smoke? Cigarettes _____ Packs daily _____ How many years _____ Pipe _____ Cigar _____ Snuff _____		
8. Have you ever had a problem with abnormal bleeding?		

9. Do you have or have you had any of the following? (If yes, check):
❐ AIDS (or HIV positive) ❐ Epilepsy ❐ Hepatitis ❐ Liver disease
❐ Alcohol or drug dependence ❐ Diabetes ❐ High Blood Pressure ❐ Rheumatic Fever
❐ Anemia ❐ Heart Disease ❐ Joint replacement ❐ Ulcers
❐ Asthma ❐ Heart Murmur ❐ Kidney disease ❐ Veneral disease

10. Is there any problem or condition not mentioned above that you think we should know about?
______

THIS SECTION: WOMEN ONLY	Yes	No	
11. Are you pregnant?			If so, what month?
12. Do you take birth control pills?			
If yes, are you aware that taking antibiotics may affect the birth control pill's effectiveness?			
13. Have you reached menopause? Do you have any symptoms?			If yes, what?

Patient's signature	Date	Dr's. initials

Updated ______ ______ ______ ______ ______ ______

DENTAL HISTORY

YOUR DENTIST'S NAME

HOW LONG HAVE YOU BEEN HIS/HER PATIENT?

WHEN WAS YOUR LAST VISIT TO HIS/HER OFFICE? WHAT WAS DONE?

HAVE YOU ALWAYS HAD REGULAR DENTAL CARE?

HOW OFTEN DO YOU HAVE YOUR TEETH PROFESSIONALLY CLEANED?

WHAT IS THE REASON FOR THIS VISIT?

HOW LONG HAVE YOU BEEN AWARE OF THE PROBLEM?

IN YOUR OPINION, WHAT IS YOUR GENERAL DENTAL CONDITION?

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH?
IF NO, WHY?

ARE YOU SATISFIED WITH YOUR ABILITY TO CHEW?

ARE YOUR TEETH VERY IMPORTANT TO YOU?

HAVE YOU CONSIDERED / ARE YOU CONSIDERING DENTAL IMPLANTS TO REPLACE MISSING TEETH?

ARE YOUR TEETH PAINFUL? ARE YOUR GUMS PAINFUL?

ARE YOU AWARE OF LOOSE TEETH?

DO YOUR GUMS BLEED? IF YES, WHEN?

ARE YOU CONSCIOUS OF A BAD TASTE? OF BAD BREATH?

HAVE YOU EVER HAD PERIODONTAL TREATMENT?
IF YES, WHAT TYPE? WHEN?

HAVE YOU EVER HAD "DEEP CLEANINGS"? WHEN?

HAVE YOU EVER HAD ORTHODONTICS (BRACES)? ROOT CANAL TREATMENT?

HAVE YOU EVER HAD A SERIOUS PROBLEM ASSOCIATED WITH DENTAL TREATMENT?
IF YES, EXPLAIN

DO YOU HAVE ANY PARTICULAR MOUTH HABIT? IF YES, WHAT?

DO YOU CLENCH _____ GRIND _____ GRIT _____ YOUR TEETH? WHEN?

HAVE YOU EVER WORN A "NIGHT GUARD"?

HAVE YOU EXPERIENCED: TIRED JAW _____ CLICKING IN JAW JOINT _____ TIRED OR SORE MUSCLES _____ ACHE IN JAW JOINT OR FACE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? WHEN DO YOU BRUSH?

WHAT TYPE OF TOOTHBRUSH DO YOU USE? HARD _____ MEDIUM _____ SOFT _____

HOW DO YOU BRUSH? UP AND DOWN _____ BACK AND FORTH _____ SCRUB _____

DO YOU USE DENTAL FLOSS? IF YES, HOW OFTEN DO YOU FLOSS?

DO YOU USE ANY OF THE FOLLOWING? TOOTHPICKS _____ PROXABRUSH _____ RUBBER TIP _____
ELECTRIC TOOTHBRUSH _____ STIMUDENTS _____ WATER PIK _____ OTHER _____

THANK YOU FOR YOUR COOPERATION