

PHILLIP J. ERNST, D.D.S., M.S.

Practice Limited to Periodontics
110 N. 16th Street, Suite 17
Norfolk, NE 68701
Telephone: 402/371-4885

REGISTRATION AND HEALTH HISTORY

Name first middle last Social Security No.

Address street city zip code

Date of Birth Home Phone

Marital Status Phone number where you can be reached or a message left during office hours

Your Place of Employment Spouse's Place of Employment

Name of Insurance Company Policy Holder

Identification Numbers Social Security # of Insured Date of Birth of Insured

Referred to Our Office By Name of Your Physician

How long have you been a patient of your present dentist?

Have we treated any of your family or friends? Whom?

We are having you fill out this medical and dental history because we are interested in your total health. Even though some of the questions do not seem to be related just to "gum" problems, please be assured that they might be, and that your answers will be kept in the strictest confidence.

DENTAL HISTORY

Circle One

Are you experiencing any discomfort in your mouth at this time? Yes No

Do you frequently have bleeding gums after brushing? Yes No

Have you ever had gum boils or abscesses? Yes No

Have you ever had any teeth extracted because of periodontal disease (pyorrhea)? Yes No

Have you ever had gum treatment? Yes No

If yes, when and by whom:

Do you have any teeth which have shifted position recently? Yes No

Do you put foreign objects between teeth? pipe, hairpins, etc.? Yes No

Are you aware of any loose teeth? Yes No

Do you frequently, have a bad taste in your mouth? Yes No

Do you frequently, clench or grind teeth when tired, tense, or asleep? Yes No

Do your jaws, cheeks, or ears ever ache? Yes No

Do you frequently wedge food between your teeth? Yes No

Do you have teeth that are sensitive to hot, cold, or sweets? Yes No

Do you form calculus (tartar) on your teeth rapidly? Yes No

Do you have a parent who lost all their teeth? Yes No

Do you think you would be disturbed if you had to lose your teeth and wear dentures? Yes No

Have you ever had orthodontic treatment? (braces) Yes No

Have you been seeing a dentist on a regular basis? Yes No

Last time your teeth were cleaned?

Type of brush Bristle: HARD, SOFT, MEDIUM, (circle)

Other hygiene aids: dental floss, rubber tip, water pik, electric toothbrush? (circle which)

(Please continue on the other side)

MEDICAL HISTORY

Circle One

Have you ever been in the hospital?Yes No

For what reason? _____

My last physical examination was:

Date _____

Results? _____

Are you being treated by a physician now?Yes No

Are you taking any medications or pills of any kind, prescription or non prescription?Yes No

What? _____

Are you allergic to or have you had any ill effects from any local anesthetic or other drug or medicine? ...Yes No

What? _____

Does aspirin or codeine upset your stomach? Yes No

Have you take ACTH or cortisone in the past year? Yes No

Have you taken Fosamax/Actonel/Boniva or any other Osteoporosis medications?Yes No

Have you or any member of your family had diabetes? Yes No

Have you ever used recreational drugs?Yes No

HAVE YOU EVER HAD?

Asthma Yes No

Tuberculosis Yes No

Anemia Yes No

Hepatitis or Jaundice Yes No

Blood transfusions Yes No

HIV or Aids Yes No

X-ray therapy to head or neck Yes No

Epilepsy or seizures Yes No

High or low blood pressure Yes No

History of heart murmur / Mitralvalve Prolapse..... Yes No

Rheumatic fever Yes No

Venereal disease Yes No

Frequent cold sores Yes No

Fainting spells Yes No

Nervous disorders Yes No

Arthritis Yes No

Joint replacement Yes No

Kidney or Liver involvement Yes No

Any form of tumor or malignant growth? Yes No

Do you wear contact lenses? Yes No

Glaucoma Yes No

Have you ever had heart trouble? Yes No

Do you have pain in chest upon exertion? Yes No

Do you get short of breath easily? Yes No

Do your ankles swell often? Yes No

Do you require extra pillows when you sleep? Yes No

Do you fatigue easily? Yes No

Do you wear a pacemaker? Yes No

Have you had heart surgery? Yes No

For what: _____

Blood pressure: _____ / _____ on _____ / _____ / _____

Have you had abnormal bleeding from a cut or tooth extraction?Yes No

Female: Are you pregnant at the present time?Yes No

Delivery date: _____

Have you reached menopause?Yes No

Date: _____ Your Signature: _____

AUTHORITY TO PERFORM SERVICES

Patient's Name _____ Date _____

Address _____

I hereby grant the authority to: **PHILLIP J. ERNST, D.D.S., M.S.**

To administer any treatment; or to administer such anesthetics; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient; and also agree to accept financial responsibility for payment of the account as a result of treatment of the above named patient.

Signed _____

Authorization must be signed by the patient, or by the parent or legal guardian in the case of a minor.