

Welcome to KM Perio. Please assist us by completing this form.

GENERAL INFORMATION

THE FOLLOWING INFORMATION IS CONFIDENTIAL AND FOR OUR RECORDS ONLY.

Date _____

Patient's Name: Mr/Mst/Mrs/Ms Surname: _____ Forename: _____

Date of Birth _____ Age _____

Sex: Male/Female Marital Status _____

Residence Address _____

Telephone _____

Email _____

Name of Dentist _____

How long have you been under his/her care? _____

Name and Address of GP (General Practitioner) _____

GP (General Practitioner) Telephone _____

Who may we thank for referring you to this Practice?

Why were you referred to a periodontist? _____

Are you covered by dental insurance? _____

Person Responsible for This Account _____

Person to Notify in Case of Emergency _____

**Dr. kuljeet Mehta, BDS, FDS RCS (Eng), MClintDent, MRD (Perio) RCS (Ed) Registered Specialists in Periodontics.
Practice Limited to Periodontics and Dental Implants.**

**Procedures include: Treatment of Periodontal Disease - Gum Disease, Dental Implants, Cosmetic Periodontics
including Gum Grafting, Crown Lengthening, Ridge Preservation, Bone Regeneration & Bone Grafting.**

**Address: Suite 5 • 1 Harley Street, London, W1G 9QD • Telephone: 020-7580-2294 • Fax: 0200-7580- 5357 •
Email: info@kmperio.co.uk • www.kmperio.co.uk**

GENERAL HEALTH

Circle One

- What is your estimation of your general health? GOOD – FAIR – POOR
- Yes No Are you now under the regular care of a Doctor, Hospital, Clinic or Specialist?
 If so, for what? _____
- Yes No Have you had any major operations, hospitalization or illnesses?
 If so, for what? _____
- Yes No Are you taking any pills, medication or drugs?
 If so, please list. _____
- Yes No Have you had any unusual reaction or allergies to any medications, materials or foods?
 If so, please list. _____

- Have you ever had a reaction to any of the following: (PLEASE CHECK?)
- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Dental anesthetic |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Bisphosphonates |

- Yes No Do you smoke?
- Yes No Do you drink alcohol?
- Yes No Has any member or your family had tuberculosis, diabetes, heart disease, allergies, bleeding problems or cancer? If yes, who? _____

- Do you have or have you ever had: (PLEASE CHECK)
- | | |
|---|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> HIV POSITIVE, AIDS or CJD |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Ulcers (stomach or duodenal) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney or bladder trouble |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid or parathyroid disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma or difficulty breathing |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Anemia or other blood disorder |
| <input type="checkbox"/> Tumors or growths | <input type="checkbox"/> Dizziness or light headaches |
| <input type="checkbox"/> X-ray or radiation therapy | <input type="checkbox"/> Arthritis or rheumatism |
| <input type="checkbox"/> Rashes or skin disorders | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> A replacement valve or pacemaker | <input type="checkbox"/> Rheumatic fever or Heart murmur |
| <input type="checkbox"/> Condition requiring cortisone or other steroids | |
| <input type="checkbox"/> Hepatitis, jaundice, cirrhosis of liver or other liver disease | |
| <input type="checkbox"/> Shortness of breath or chest pains upon exertion | |
| <input type="checkbox"/> Tuberculosis, bronchitis, emphysema or other lung disease | |
| <input type="checkbox"/> Epilepsy, seizures, convulsions or fainting spells | |
| <input type="checkbox"/> Any history of family illnesses e.g. sicklecell anaemia, thalassaemia, diabetes? | |
| <input type="checkbox"/> Sedation or general anaesthetic | |
| <input type="checkbox"/> Abnormal bleeding after a cut or a tooth extraction | |

WOMEN ONLY:

- Yes No Are you pregnant? (Date of delivery _____)
- Yes No Are you taking birth control pills?

Yes No Are there any other aspects concerning your health that you think we should know about?

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DENTAL HEALTH

- Yes No Do you consider yourself in good dental health?
Yes No Do you think that your teeth are affecting your health in any way?
Yes No Are you dissatisfied with the appearance of your teeth?
Yes No Are you dissatisfied with your chewing ability?
Have you ever had?
____ Orthodontic treatment (Braces)
____ Oral Surgery (Extraction, etc.)
____ Periodontal treatment
____ Your teeth ground or bite adjusted
____ A bite plate or other appliance
Yes No Have you noticed any loosening of your teeth?
Yes No Does food tends to become caught between your teeth?
Yes No Do you suffer from pain and/or swelling of your gums?
Yes No Do your gums often bleed when you brush your teeth?
Yes No Do you have any bad breath or taste in your mouth?
Yes No Are you missing any teeth?
Reasons: Decay () Gum Disease () Other ()
Yes No Have missing teeth been replaced?
When did you last have your teeth cleaned before this appointment? _____
How long before that? _____
How often do you see your dentist? _____
How often and when do you brush your teeth? _____
Do you use: Hand tooth brush () Electric toothbrush ()
Is your toothbrush: Soft () Medium () Hard ()
What else do you use to clean your teeth? (Dental floss, Tepe Interdental Brush, toothpick, waterpik, etc.)

How often? _____
Yes No Do you feel apprehensive when you are having a dental treatment?
Yes No Does the fear of pain makes you postpone your dental treatment?
Yes No Is it important to you to keep your teeth?
Yes No Would you spend fifteen minute a day in order to keep your natural teeth?
Yes No Would you be tremendously disturbed if you had to lose your teeth and wear false teeth?
Yes No Do you have any idea what periodontal treatments are and what they do for you?

What is your chief complain concerning your mouth or teeth? _____

To the best of my knowledge all of the above answers are true and correct. If I have any change in my health, I will inform Dr. Kuljeet Mehta at my next appointment.

Signature of Patient

Date

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