Dr. Giorgio Petricca Inc.
Certified Specialist in Periodontics

Periodontal & Implant Clinic

Nanaimo Location
Suite 503 - 495 Dunsmuir St., Nanaimo BC V9R 6B9
(250) 754-1233

OFFICE ACCOUNT #______________

MEDICAL & DENTAL HISTORY

Patient's Name ______________________________ Birth date (Y)_____/ (M)_____/ (D)_____

Home Address ______________________________ City________________ Prov__________ Postal Code ____________

Tel. # (Hm)________________ (Wrk)________________ Cell Phone # ________________ Your Email: ________________

Person responsible for the account ______________________________ Spouse's name ______________________________

Your General Dentist ______________________________ Care Card # ______________________________

DENTAL INSURANCE - PLAN #1

Your Employer ______________________________

Insurance Co. ______________________________

Group # ____________________ ID #______________

Division #____________________ % Coverage __________

Plan holder DOB ___/___/___/ Dependent # ______________
YY / MM / DD

DENTAL INSURANCE - PLAN #2

Spouse's Employer ______________________________

Insurance Co. ______________________________

Group # ____________________ ID #______________

Division #____________________ % Coverage __________

Plan holder DOB ___/___/___/ Dependent # ______________
YY / MM / DD

MEDICAL HISTORY (this information is confidential and is for our records only)

1. Name of physician(s) ______________________________ Name & Type of Medical Specialist ______________________________
2. Date of last physical exam ______________________________
3. If you are under a physician's care, for what conditions ?______________________________
4. Have you be**en advised by your physician or dentist that you must take antibiotics prior to dental treatment?** If so, for what conditions(s)? Please Check
5. Reumatic Fever , Damaged or Artificial Heart Valves , Heart Murmur , Congenital Heart Defect , or….
   Artificial Hip or Joint Replacement , Organ Transplant or Immunosuppressive Disease, Please check & if you are **Allergic or Reacted to**

- ❑ Local Anesthetic (freezing)
- ❑ Penicillin
- ❑ Sulfa drugs
- ❑ Other antibiotics (list______________________________
  Aspirin, Ibuprofen, Tylenol
- ❑ Codeine, or other Narcotics
- ❑ Sedatives, Sleeping Pills, or Tranquilizers
- ❑ Latex or rubber products
- ❑ Other (i.e. foods, metals, soaps, etc.)
  ____

6.Please check if you have any of the following disorders or health problems (circle the sub-type):

- ❑ **Heart Problems or History of:** artificial heart valves, heart murmur, heart attack, stroke, angina, bypass, arrhythmia, pacemaker, chest pains
- ❑ High or Low Blood Pressure
- ❑ Blood or Bleeding Disorders
- ❑ Frequent Headaches
- ❑ Diabetes: Type I or Type II
- ❑ Breathing or lung disorders
- ❑ Hepatitis; Type: A B C
- ❑ Other Liver Disease
- ❑ Immunosuppressive Disease (HIV/AIDS)
- ❑ Cancer When ________ Type _________
- ❑ Seasonal Allergies, Hives, Rashes, Sinus Problems, Hay Fever
- ❑ Epilepsy, Seizures, Fainting Spells
- ❑ Arthritis: Rheumatoid or Osteo
- ❑ Ulcers, Acid Reflux or Hiatus Hernia
- ❑ Kidney Disease
- ❑ Goiter or Thyroid Disease
  Hypothyroidism or Hyperthyroidism
- ❑ Nervous Problems
  Anxiety or Panic Attacks
- ❑ Eye Problems or Contact Lenses
- ❑ Artificial Joint(s)
  When _________ Joint ______________
- ❑ Cold sores

7. Please list diseases, conditions or problems not listed above______________________________

8. Please check if you are **Presently Taking** any of the following **Drugs/Medications, then list them below:**

- ❑ High Blood Pressure Pills
- ❑ Anticoagulants / Blood Thinners (Coumadin, Warfarin)
- ❑ ASPIRIN / ASA
- ❑ Heart Drugs (Digitalis, Nitroglycerin etc.)
- ❑ Diabetic drugs
- ❑ Antibiotics (Penicillin etc.)
- ❑ Antihistamines
- ❑ Asthma drugs
- ❑ Antidepressants
- ❑ Sedatives, Anti-anxiety, Sleeping Pills
- ❑ Oral contraceptives
- ❑ Cortisone, Prednisone or Steroids
- ❑ Hormone Therapy (HRT)
- ❑ Tylenol or Ibuprofen
- ❑ Herbal or Naturopathic Compounds
- ❑ Other ______________________________

9. Please list **Any Prescription or Non-Prescription Drugs/Medications** taken within the last 6 months. **Include Herbal and Naturopathic Products and Supplements:**

1. ______	4. ______	7. ______	10. ______
2. ______	5. ______	8. ______	11. ______
3. ______	6. ______	9. ______	12. ______

10. **Have you ever Smoked or used Tobacco Products ?** Yes No How many years? ______ When did you quit?

~~11. Have you ever~~ used or continue to use any illicit / illegal drugs? Yes No Do you abuse alchohol? Yes No

12. Have you ever had excessive bruising or bleeding associated with previous extractions, operations or trauma? Yes No

13. Have you ever had a blood transfusion? Yes No When? / Year: ______

14. For Women: Are you pregnant? Yes No Uncertain or Planning. Are you Nursing? Yes No

Person(s) & Phone # to be contacted in case of an Emergency ______

I certify that I have read and understood the above questions. I will not hold the dentist or any other member of the staff, responsible for any errors or omissions that I may have made in completion of this form. **I authorize the dentist or members of the staff to perform diagnostic and treatment procedures as may be necessary for proper dental care.** I understand that I am financially responsible for payments in full, of all accounts not paid, in whole or in part by my dental insurance carrier or payer of my dental benefits. **All information on this form is confidential.**

Signature of Patient or Guardian ______ ***Date*** ______

DENTAL HISTORY

1. Date of Last Dental Exam ______ Date of Last Cleaning ______

2. How often do you have your teeth cleaned? Every... 3 mo. 4 mo. 6 mo. 9 mo. 12 mo. Not regularly

3. What is your **Main Dental Concern,** if any? ______

4. List any **Dental Treatment that is Planned** in the future (crowns, bridges, dentures, braces etc.) ______

5. Do you suffer from major dental anxiety? Yes No Have you had sedation for any dental treatment before? Yes No

6. Have you previously been treated by a Periodontist? Yes No Name of Periodontist:
______ What treatment? ______ When?
______

8. Have you had any Serious Trouble or Complications associated with any Previous Dental Treatment? Yes No
Explain ______

9. Do you have Sensitive or Painful Teeth? Yes No Where: ______ Is sensitivity shortlived (< 5 secs or Lingering (> 10 secs)

10. Please check which oral hygiene method(s) you use/perform and how often:

☐ **Toothbrushing** **How Often:** ______ 8. ☐ Mouth wash (Type) ______
D **.Dental Flossing** **How Often:** ______ ☐ Toothpicks
☐ Electric Toothbrush (Type) ______ ☐ Floss Threader or Superfloss (for under bridges or braces)
☐ Toothpaste for Sensitivity (Type) ______ ☐ Whitening Toothpaste or "Bleaching" Products

11. Do you grind or clench your teeth? Yes No

12. Do you have jaw (TMJ / TMD) problems? Yes No. Describe ______

13. Have you had your wisdom teeth removed, how many? ______ When? ______

14. Have you have had braces (orthodontic treatment), if so, when? ______

15. Do you wear any type of removable dental appliance (Denture, Retainer, Mouth Guard or Night Guard, etc.)? Yes No

16.Gum Disease or early tooth loss? Yes No

Yes No

17. Have you ever worn a plastic or metal tounque or lip piercing ?

18. Have you had any reactions to products, medications or insturments used in the dental office? Yes No
Explain ______

Privacy and Confidentiality: All information you have provided will be kept confidential in accordance with Privacy laws and Regulations of the College of Dental Surgeons of BC.

MEDICAL HISTORY UPDATE

Initial Date	Initial Date	Initial Date	Initial Date
1. ______	4. ______	7. ______	10. ______
2. ______	5. ______	8. ______	11. ______
3. ______	6. ______	9. ______	12. ______