

Dr. Giorgio Petricca Inc.

Certified Specialist in Periodontics

Victoria Location

Suite 105 - 324 Goldstream Avenue Victoria BC V9B 2W3
(778) 406-1077

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

DENTAL INSURANCE - PLAN #2

Your Employer _____

Spouse's Employer _____

Insurance Co. _____

Insurance Co. _____

Group # _____ ID # _____

Group # _____ ID # _____

Division # _____ % Coverage _____

Division # _____ % Coverage _____

Plan holder DOB ____/____/____/ Dependent # _____
YY / MM / DD

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 **been advised by your physician or dentist that you must take antibiotics prior to dental treatment?** If so, for what conditions(s)? Please Check

5. Rheumatic 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):

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

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:

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

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 alcohol? 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:
- | | |
|---|---|
| <input checked="" type="checkbox"/> Toothbrushing How Often: _____ | <input type="checkbox"/> Mouth wash (Type) _____ |
| D .Dental Flossing How Often: _____ | <input type="checkbox"/> Toothpicks |
| <input type="checkbox"/> Electric Toothbrush (Type) _____ | <input type="checkbox"/> Floss Threader or Superfloss (for under bridges or braces) |
| <input type="checkbox"/> Toothpaste for Sensitivity (Type) _____ | <input type="checkbox"/> 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
17. Have you ever worn a plastic or metal tongue or lip piercing? Yes No
18. Have you had any reactions to products, medications or instruments 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. _____ | |