NL Periodontics and Dental Implants

☐ DR. TONY CRIVELLO DMD, MS, FRCD(C)
☐ DR. DANIEL E. PRICE DMD, FRCD(C)

120 Torbay Road, Suite W250
St. John's, NL A1A 2G8
T (709) 754-2500 F (709) 754-3969
info@nlperioandimplants.ca
www.nlperioandimplants.ca

Patient Information

Name _____ Date of Birth _____ Marital Status _____
Address _____ Postal Code _____
E-mail Address _____
Occupation _____ Home Phone _____ Bus. Phone _____
Spouse _____ Occupation _____ Bus. Phone _____
Dentist _____ Town _____ How Long _____
Physician _____ Town _____ How Long _____
Dental Insurance? Yes No Carrier: (eg. Blue Cross, Sunlife) _____ Policy # _____
Employer _____ Cert./I.D. # _____
Reason for visit _____

Medical History (Please circle Yes or No)

1. Are you in good health? ..... Y N
2. Have you been under the care of a physician during the last 2 years? ..... Y N
   Condition being treated (Please Explain) _____
3. Date of last physical examination _____
4. Have you had any serious illness or operation? ..... Y N
5. Circle any of the following which you have had or have at present:

Heart Attack	Kidney Trouble	AIDS (HIV Pos)	Heart Disease or Failure
Stomach Ulcers	Liver Disease	Heart Murmur	Tuberculosis (TB)
Hepatitis	Congenital Heart Lesions	Fainting	Allergies or Hives
Rheumatic Fever	Asthma	Blood Transfusion	Rheumatic Heart Disease
Chest Pain	Hemophilia	Artificial Heart Valve	Stroke
Drug Addiction	Heart Pacemaker	Diabetes	Venereal Disease
Heart Surgery	Epilepsy	Arthritis	High Blood Pressure
Rheumatism	Nervousness	Low Blood Pressure	Artificial Joint
Psychiatric Tx.			

6. Have you had abnormal bleeding with extractions, surgery, or trauma? ..... Y N
7. Are you allergic or have you reacted adversely to: (circle any of the following)
   Local anaesthetics (Novocaine, Lidocaine, Freezing) ..... Y N
   Penicillin or other antibiotics (Sulpha drugs, etc.) ..... Y N
   Barbiturates, sedatives, or sleeping pills ..... Y N
   Aspirin or Tylenol (ASA or Acetaminophen) ..... Y N
   Codeine or other narcotics ..... Y N
   Other (please specify) ..... Y N
9. Are you taking any drug or medicine? ..... Y N
   If so, what are you taking? .....
10. Have you had in the past or do you presently have any disease, condition, or problem not listed above? . Y N
11. WOMEN: Are you pregnant? _____ Month? _____
12. Do you smoke or have you smoked in the past? _____ How Much? _____

Dental History (Please circle Yes or No)

1. Are you having any discomfort at this time? ..... Y N
2. Do you clench or grind your teeth? ..... Y N
3. Have you had an serious trouble or an anxious experience with any previous dental treatment ..... Y N
4. How often do you clean your teeth (please circle) 1, 2, 3 or (indicate)times per day?
5. Do you use dental floss, toothpicks, mouthwash (please circle) ..... Y N
6. When did you last have your teeth cleaned? (Give approx. Date)
7. Would you be disturbed if you had to lose teeth and wear false teeth? ..... Y N
8. Do you currently experience? (circle any that apply)

Loose teeth	Earache	Problems flossing	Bleeding gums
Headache	Unsatisfactory dentures	Sore gums	Neck pain clicking in jaw joint

9. Have you had? (circle any that apply)

Orthodontics / Braces	TMJ or Bite Problems	Periodontics / Gum Treatment
Crowns or Bridge	Bite Plane / Night Guard	Partial Dentures

I understand that it is my responsibility to inform this office of any changes in my medical status. I also accept full responsibility for payment on my account regardless of any third party insurance involvement.

Patient (Parent) Signature _____ Date _____