

SOUTH JERSEY PERIODONTICS & DENTAL IMPLANTS, LLC

DANIEL KUBIKIAN, DMD

Patient Health Record

In order to help me provide you proper dental treatment, please answer the following questions.
Your responses are confidential. Thank you.

Name: _____
Home Address: _____

Phone: _____
E-Mail: _____
Employer Name: _____
Phone: _____
Social Security No.: _____
Dental Insurance: _____

Date: _____
Referring Dentist: _____
Last Dental Visit: _____
Patient's Physician: _____
Age: _____
Date of Birth: _____
Reason for Visit: _____

MEDICAL HEALTH

On any medications? _____ Yes No
Purpose of medication: _____
Last Physical Exam: _____
Have you had any of the following:
Heart Disease Yes No
Rheumatic Fever Yes No
Abnormal Blood Pressure Yes No
Ulcers Yes No
Tuberculosis or Lung Disease Yes No
Diabetes or Hypoglycemia Yes No
Epilepsy Yes No
Anemia Yes No
Do you smoke? Yes No
Have you ever taken biphosphonates? Yes No
Heart Murmur Yes No
Asthma, Hayfever, Sinus Trouble..... Yes No
Cancer Yes No
Hepatitis Yes No
Arthritis Yes No
Stroke Yes No
AIDS/HIV Yes No
Herpes or Cold Sores Yes No
Prosthetic Joints Yes No

Are you allergic to Penicillin Codeine Local Anesthetics Other Meds
Specify: _____
Do you have Excessive Urination, Thirst, or Hunger? Any recent weight changes?

Women:
Are you taking Oral Contraceptives or other Hormone Supplements? _____
If so, what? _____

Other important medical info: _____

PERIODONTAL HEALTH

Do your gums bleed when brushing or flossing? Yes No
Do your gums feel swollen or tender? Yes No
Do you have any problems chewing? Yes No
Are any teeth loose? Yes No
Which ones? _____
Are your teeth sensitive or painful to cold liquids or food? Yes No
Do you notice any bad breath or bad taste in your mouth? Yes No
How often do you brush your teeth? _____
What texture toothbrush do you use? Soft Medium Hard
Do you floss your teeth? Yes No

Patient Signature