Periodontal Assessment

Gingiva

☐ Healthy ☐ Hypertrophic ☐ Hemorrhagic ☐ Fibrous
☐ Edematous ☐ Recession ☐ Exudate ☐ Cyanotic
☐ Ulcerated ☐ Clefting ☐ Frenum Pull

Gingivitis ☐ WNL
☐ Localized ☐ Generalized ☐ Mild ☐ Moderate ☐ Severe ☐ Acute
☐ Hormone ☐ Medication

Periodontitis ☐ WNL
☐ Localized ☐ Generalized ☐ Early ☐ Moderate ☐ Advanced

Calculus ☐ NONE
☐ Supra ☐ Localized ☐ Generalized ☐ Light ☐ Moderate ☐ Heavy
☐ Sub ☐ Localized ☐ Generalized ☐ Light ☐ Moderate ☐ Heavy

Stain ☐ NONE
☐ Localized ☐ Generalized ☐ Light ☐ Moderate ☐ Heavy

Plaque Index ☐ NONE
☐ Supra ☐ Localized ☐ Generalized ☐ Light ☐ Moderate ☐ Heavy
☐ Sub ☐ Localized ☐ Generalized ☐ Light ☐ Moderate ☐ Heavy

Comments/Oral Hygiene/Proposed Treatment Plan:

Welcome to the Port Perry Dental Centre

Date: ____________

Personal Information

Name: ____________
Address: ____________ City: ____________ PC: ____________
Email Address: ____________
Date of Birth: MM / DD / YYYY (H) Tel: ____________ (W) Tel: ____________
Emergency Contact: ____________ Tel: ____________
Family Doctor: ____________ Tel: ____________
Drug Store Used: ____________ Tel: ____________
Who referred you to this dental office? ____________

Financial Information

Account will be paid by: ☐ Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other
Person Responsible for account: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other
Name of Parent/Guardian: ____________
Please complete all information if different from above.
Policy Holder's Name: ____________ (H) Tel: ____________
Address: ____________
Policy Holder's Date of Birth: ____________
Employed by: ____________ Ins Co. ____________
Grp/Plan # ____________ Cert/ID# ____________
Any additional insurance coverage? ____________

Health History

1. Are you being treated for any medical condition at present or within the past year? If yes, please explain ____________ ☐ Yes ☐ No
2. Have you recently or are you presently taking any prescription or non-prescription drugs (including vitamins and naturopathic or homeopathic remedies)? ☐ Yes ☐ No
3. Medication ____________ Reason ____________
   Medication ____________ Reason ____________
   Medication ____________ Reason ____________
   Medication ____________ Reason ____________
4. Have you ever had any adverse reaction to, or been advised against taking any medications or injections? ☐ Yes ☐ No
   ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Codeine ☐ Local Anaesthetic ☐ Other
5. Do you have any allergies? E.g. Latex/rubber or metal allergies? ☐ Yes ☐ No
6. Have you ever fainted during dental or medical treatment? ☐ Yes ☐ No
7. Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders? Please explain ____________ ☐ Yes ☐ No
8. Have you been advised to take antibiotics before dental work? ☐ Yes ☐ No
9. Do you have or have you ever had any chest pain, shortness of breath or any heart palpitation without exertion? ☐ Yes ☐ No
10. Do you or did you smoke? How much? ____________ ☐ Yes ☐ No

PLEASE TURN OVER

11. Women Only: Are you pregnant?_____ If pregnant delivery date? _______________

12. Indicate which of the following you presently have or ever had:

- ☐ A.I.D.S.
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Anorexia/Bulimia
- ☐ Artificial heart valve
- ☐ Arthritis/rheumatism
- ☐ Artificial joints (hips, knee)
- ☐ Asthma/Bronchitis
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Circulation problems
- ☐ Congenital heart lesions
- ☐ Cortisone/Steroid
- ☐ Diabetes
- ☐ Drug/alcohol dependence
- ☐ Emphysema
- ☐ Epilepsy or seizures
- ☐ Glandular disorders
- ☐ Glaucoma
- ☐ Head/Neck Injuries
- ☐ Heart Disease/Attack
- ☐ Heart pacemaker/surgery
- ☐ Heart rhythm disorder
- ☐ Hepatitis A/B/C
- ☐ Herpes
- ☐ High/Low Blood pressure
- ☐ HIV Positive
- ☐ Hodgkin's Disease
- ☐ Hyperglycemic
- ☐ Hypoglycemic
- ☐ Hypertension
- ☐ Jaundice
- ☐ Kidney/Liver Disease
- ☐ Leukemia
- ☐ Lung disease
- ☐ Malignant Hyperthermia
- ☐ Mental/Nervous Disorder
- ☐ Heart Murmur
- ☐ Organ Transplant/Implant
- ☐ Psychiatric disorders
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic/Scarlet fever
- ☐ Sickle Cell disease
- ☐ Sinus trouble
- ☐ Stomach/intestinal problem
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other
- ☐ Mitral Valve Prolaspe with regurgitation
- ☐ Mitral Valve Prolaspe without regurgitation

Dental History

1. What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other
2. How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Other
3. When was your last dental visit?____________________ Last X -Rays? ____________
4. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Pressure ☐ Other
5. Do you grind or clench your teeth? ☐ Yes ☐ No
6. Do your jaws crack or pop when you open widely? ☐ Yes ☐ No
7. Have you ever had local anaesthetic (freezing)? ☐ Yes ☐ No
8. Have you ever had the following: ☐ Bridgework ☐ Crowns ☐ Root Canal ☐ Full or Partial Dentures ☐ Orthodontic(Braces) ☐ Periodontal Disease ☐ Implants
9. Are you satisfied with your smile? Specify______________________ ☐ Yes ☐ No

General Release & Parental Consent

I, the undersigned understand that this information is important to my or my dependants treatment. I certify that all the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my or my dependants medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to assume all fees associated with my or my dependants dental treatment/diagnostic procedures.

Signature ______________________________________ Date ____________________

Print Name ____

Clinical Examination

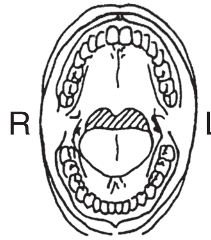
Extra Oral WNL
- Head ☐
- Neck ☐
- Lymph Nodes/Skin/Other ☐

Intra Oral WNL
- Hard/Soft Palate ☐
- Floor of Mouth/Tongue ☐
- Buccal Mucosa ☐
- Frenum Attachments ☐

Comments: ____

Oral Cancer Screen NSF ☐

Findings as marked



TMJ WNL ☐
- Crepitis ☐ ____________________
- Popping/Clicking ☐ ____________________
- Tenderness to palpation ☐ ____________________
- Pain/Muscle tension ☐ ____________________

Comments: ____

Occlusion

Right Class ____________ Overbite ____________ Midline ____________

Left Class ____________ Overjet ____________ Crossbite ____________

Crowding ____

55	54	53	52	51	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	61	62	63	64	65
55	54	53	52	51	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	61	62	63	64	65
85	84	83	82	81	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	71	72	73	74	75
85	84	83	82	81	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	71	72	73	74	75