

PERIODONTAL

Mark Forrest, D.M.D.
Periodontist/Implant Surgeon

Name (*print*) _____ Date _____

1. What is the main reason that you made an appointment in our office? _____

- | | YES | NO |
|---|--------------------------|--------------------------|
| 2. Are you having any particular dental problem?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please specify _____ | | |
| 3. Are you happy with the appearance of you teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. What are your main dental concerns at this time?
<input type="checkbox"/> Difficulty eating <input type="checkbox"/> Discomfort <input type="checkbox"/> Health <input type="checkbox"/> Prevention
<input type="checkbox"/> Fear of loss of teeth <input type="checkbox"/> Appearance of face <input type="checkbox"/> Other: _____ | | |
| 5. In your opinion what is your general dental condition?
<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Neglected | | |
| 6. Have you noticed any areas of gum recession in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you satisfied with the appearance of you teeth and gums?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had a consultation with a periodontist before? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had periodontal treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had <i>scaling and root planing</i> (deep cleaning) ? | <input type="checkbox"/> | <input type="checkbox"/> |

- If yes, when? _____
11. Are any of your teeth painful now?..... YES NO
12. Do your gums bleed?..... YES NO
13. Are you conscious of a bad taste or bad breath?..... YES NO
14. Do you breathe through your mouth **most** of the time?..... YES NO
15. Do you clench or grind your teeth during the day or night?..... YES NO
16. Do you have any jaw pain or clicking when chewing?..... YES NO
17. Are there any foods that you have difficulty chewing?..... YES NO
18. Have you noticed shifting of your teeth?..... YES NO
19. Have you ever had orthodontic treatment (braces)?..... YES NO
20. Name of your **present** general dentist: _____

How long have you been under his/her care? _____

21. When was your last dental cleaning? _____

When was the last one before that? _____

22. Name of your **previous** general dentist: _____

City: _____

When was the last time you saw him/her? _____

How long were you under his/her care? _____

23. Why did you change dentists? _____

24. Do you have any dental insurance? Yes No

If yes, please specify _____

Do you have more than one dental insurance? Yes No

If yes, please specify _____

(Over)

1. Do you use a hand toothbrush? Yes No

If yes, is it? Soft Medium Hard

2. What brushing technique do you use?

- Up & down
- Side to side
- Circular
- Scrub
- Roll

3. Do you use any of the following?

Sonicare® toothbrush How long have you been using it? _____

Electric toothbrush _____ How long have you been using it? _____ years

4. How many times a day do you brush your teeth? 1 2 3 4 times/day

5. Do you use dental floss? Yes No

If yes, how often do you use it? _____

How long have you been doing this? _____ years

Has anyone ever taught you how to properly use it? Yes No

6. What other items do you use to clean your teeth?

- Floss threaders
- Floss holder
- Proxabrush
- Sulcus brush
- Superfloss
- Hydro flosser
- Water Pik
- Other: _____

I understand that the fees for periodontal treatment that may be done for me by DR. FORREST are my responsibility. Even if I have dental insurance, I will pay my annual deductible, and an estimated percentage of the total charges. If for any reason my insurance company does not pay the claim, or pays a smaller portion than anticipated, I acknowledge that I am responsible for all amounts not paid by insurance.

I hereby authorize that my dental insurance payments are made directly to DR. MARK FORREST, otherwise payable to me.

I am aware that I will be responsible for scheduled appointments. I understand that after two consecutive appointments are broken, a fee will be charged.

All account balances due more than 60 days, regardless of insurance involvement, will bear an interest rate of 1¹/₂% per month, or \$5, whichever is greater. I agree that should this account be referred to an attorney or agency for collection that I will be responsible for all collection costs, FedEx charges, courier service charge, attorney fees, and court costs.

Signature of responsible party: _____ Date: _____