MICHAEL C. TOMS, DDS, MS
Implant Dentistry & Periodontics

Michael C. Toms, D.D.S., M.S.
5532 Muddy Creek Road, Cincinnati, Ohio 45238
(513) 922-7300

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered confidential.

Today's Date ______________________

Patient Name __________________________ Middle ___ Preferred ____________________

Date of Birth __________________Gender _________ Marital Status____________________

Home Address ___________________________ _______________________________
City State Zip

Home Phone _____________________________ Cell Phone ______________________

Email ___________________________________ Social Security # __________________

Employer's Name and Address ____

Business Phone ____________________ Occupation _____________________

Primary Physician __________________ Phone Number _________________________

Primary Physician's Address ____

Last Physical Examination Date _____________________

Primary Dentist _____________________ Phone Number __________________________

Primary Dentist Address ____

Date of Last Dental Treatment ___________ What was done? _______________________

Who may we thank for referring you to this office? _________________________________

Give your reason(s) for seeking periodontal treatment ______________________________

____

Emergency Contact ________________________ Relationship ______________________

Emergency Contact's Phone Number ___________________ Alt Number ______________

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Medical History
(Circle One)

Yes No Are you now under the regular care of a physician?
If so, for what? ______________________________

Yes No Have you had any major operations, hospitalization or illness?
If so, for what? ______________________________

Have you ever had a reaction to any of the following: ***(Please Check)***

___ Penicillin
___ Sulfa drugs
___ Codeine
___ Aspirin
___ Bisphosphonates
___ Other Allergies ______________________________
___ Sleeping pills (barbiturates)
___ Tetracycline
___ Dental anesthetic (Novocain)
___ Latex

Yes No Are you taking bisphosphonates? *(ie: Fosamax, Boniva, Reclast)* ________________

Yes No Are you taking any blood thinners? *(ie: Coumadin/Plavix)*, ________________

Yes No Are you taking any vitamins or herbal supplements? ________________

Yes No Do you smoke? How much? ____________PPD. How Often? ______________

Yes No Do you drink alcohol? How much? ________ How Often? ______________

Yes No Have you ever had any problems with surgery?

Do you have or have you ever had: ***(Please Check)***

_____ Ulcers (Stomach or Duodenal)
_____ Heart murmur/mitral valve prolapse
_____ Heart Attack
_____ Arteriosclerosis
_____ Diabetes If so, Type A (   ) Type B (   )
_____ Stroke
_____ AIDS/HIV+
_____ Anemia/blood disorder/Hemophilia
_____ Radiation therapy/Chemotherapy
_____ Cancer
_____ Artificial Joints
_____ Artificial heart valves
_____ Frequent Headaches
_____ Psychiatric care
_____ Frequent fractures or dislocations
_____ Condition requiring cortisone/steroids
_____ Jaw Pain
_____ Hepatitis, jaundice, or other liver disease
_____ Epilepsy, seizures, convulsions, fainting
_____ Shortness of breath or chest pains upon exertion
_____ Food Allergies? ______________________________
_____ Osteoporosis
_____ Kidney or bladder trouble
_____ High or low blood pressure
_____ Thyroid Disease
_____ Back problems
_____ Asthma or difficulty breathing
_____ Herpes
_____ Chemical dependency
_____ Arthritis or Rheumatism
_____ Painful or swollen joints
_____ Depression
_____ Rashes or skin disorders
_____ Dizziness or lightheadedness
_____ Sinus problems
_____ Birth Control Medication
_____ Sexually transmitted disease
_____ Pregnant
_____ Jaw Pain
_____ TB, COPD, Emphysema

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Dental History

(Circle One)

Yes No Are you currently experiencing dental pain? How long? ____________________

Yes No Do you consider yourself in good dental health?

Yes No Do you think that your teeth are affecting your health in any way?

Yes No Are you dissatisfied with the appearance of your teeth?

Yes No Are you dissatisfied with your chewing ability?

Have you ever had:

___ Orthodontic Treatment (braces) ___ Periodontal/ Gum Treatment

___ Oral Surgery (extraction(s), etc.) ___ Your teeth ground or bite adjusted

___ Night guard/bite plane or any other appliance

Yes No Have you noticed any loosening in your teeth?

Yes No Does food tend to become caught in your teeth?

Yes No Do you suffer from pain and/or swelling of your gums?

Yes No Do you have an unpleasant odor or taste in your mouth?

Yes No Are you missing any teeth?
Reasons: Decay ( ) Gum Disease ( ) Other ( ) ______________________

Yes No Did either your mother or father lose all of their natural teeth?

Yes No Sensitivity? To… ( ) Sweets ( ) Hot ( ) Cold

Yes No Do you feel apprehensive when you are having dental treatment?

Yes No Does the fear of pain make you postpone your dental treatment?

Yes No Is it important for you to keep your natural teeth?

Yes No Do you ever have any soreness, pain, clicking or popping in the area in front of your ears?

Do you:
____ Clench or grind your teeth while awake or asleep?
____ Bite your lips or cheeks regularly?
____ Hold foreign objects with your teeth?
____ Breathe primarily through your mouth?

When did you last have your teeth cleaned and where?____

How often and when do you brush your teeth? ____

Do you use: Manual/Hand toothbrush ( ) Electric toothbrush ( ) Both ( )

Is your toothbrush: Soft ( ) Medium ( ) Hard ( )

What else do you use to clean your teeth? Floss ( ) Toothpick ( ) Waterpik ( ) Other ( ).

How often? ________________________

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Medications and Pharmacy Information

Preferred Pharmacy ____

Pharmacy Phone Number ____

Do you take a Pre-Medication? If so, have you taken it today? Yes No

Medication List

____
____
____
____
____
____
____
____
____
____
____
____
____
____

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Insurance Information

Primary Dental Insurance Information:

Subscriber's Name ________________________ Subscriber's Phone Number _________________________

Subscriber's Date of Birth __________________ Subscriber's SS Number ____________________________

Employer Name ___________________________ Employer Phone Number ____________________________

Insurance Company Name __________________ Insurance Phone Number ____________________________

Member ID Number _________________________Insurance Group Number ____________________________

Secondary Dental Insurance Information:

Subscriber's Name ________________________ Subscriber's Phone Number _________________________

Subscriber's Date of Birth __________________ Subscriber's SS Number ____________________________

Employer Name ___________________________ Employer Phone Number ____________________________

Insurance Company Name __________________ Insurance Phone Number ____________________________

Member ID Number _________________________ Insurance Group Number ___________________________

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Financial and Information Policy

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change, I will inform the doctor immediately. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that all payments must be made in full to the provider before any treatment/services are provided.

Signature ____ Date ________________________