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
☐ Sleeping pills (barbiturates)
☐ Tetracycline
☐ Dental anesthetic (Novocain)
☐ Latex
☐ Other Allergies _____

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)
☐ C Diff Diarrhea
☐ Heart Attack
☐ Arteriosclerosis
☐ Diabetes If so, Type 1 (☐) Type 2 (☐)
☐ 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
☐ Infective Endocarditis

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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 _____