Elkhart Periodontics and Implants LLC
320 W. Bristol St.
Elkhart, IN 46514
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Patient Health Questionnaire

Please bring this completed form to your first appointment.

Demographic Information

Today's Date: _____

Last name: _____ Middle Initial: ____ First Name: _____

Preferred Name: _____

Sex: ☐ Male ☐ Female Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

Age: _____ Date of Birth: _____ SSN: _____

Ethnicity/Race: ☐ American Native/ Alaska Native ☐ Asian ☐ Black/ African American ☐ Hispanic/ Latino ☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Other ☐ Decline

Contact Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Primary Phone: ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Occupation: _____ Employer/School: _____

Employer/School Address: _____

Legal Guardian/ Responsible Party: _____ Relationship to Patient: _____

Marital/Partner Information

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partnered

Spouse's Name: _____ Date of Birth: _____

Spouse's SSN: _____ Spouse's Employer: _____

Referral Information – How did you hear about us?

Referral Name/Source: _____

Provider Information

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ City, State, and ZIP: _____

☐ I authorize communications and consent to release and/or obtain any of my information regarding my treatment with Kelly M. Hill, DDS, MSD including a full report of examination findings, diagnosis, treatment plan and progress report between Elkhart Periodontics and Implants and the professional care team listed above.

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ City, State, and ZIP: _____

☐ I authorize communications and consent to release and/or obtain any of my information regarding my treatment with Kelly M. Hill, DDS, MSD including a full report of examination findings, diagnosis, treatment plan and progress report between Elkhart Periodontics and Implants and the professional care team listed above.

Additional Provider Office (if applicable): _____ Last Visit: _____

Doctor Name: _____ City, State, and ZIP: _____

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Preferred Pharmacy (if applicable): _____

Street Address: _____ City, State, and ZIP: _____

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Patient Initials: _____

☐ I acknowledge that I have been offered a copy of the Office Privacy Notice and I am familiar with my rights as a patient of with Kelly M. Hill, DDS, MSD and Elkhart Periodontics and Implants. I understand this practice is Fee for Service Out-of-Network and regardless of my insurance coverage, I am responsible for any charges incurred at the time of my visit.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

My signature above certifies that the information listed on this form is accurate and complete to the best of my knowledge.

Health History

Reason for today's visit:

_____

_____

Date of last dental visit: _____ Date of last dental x-rays: _____ Date of last dental cleaning: _____

How often do you: Brush: _____ Floss: _____ Rinse: _____

Please describe your current health (circle one): Excellent Good Fair Poor

Current Symptoms

Please check all symptoms you are experiencing:

- ☐ Bleeding gums when brushing
- ☐ Bleeding gums when flossing
- ☐ Pain when brushing/flossing
- ☐ Loosening of teeth
- ☐ Sores or lumps in mouth
- ☐ Sensitivity to hot, cold, sweet, or sour foods/liquids
  If yes, please explain: _____
- ☐ Jaw clicking
- ☐ Jaw pain (joint, ear, side of face)
- ☐ Difficulty opening/closing jaw
- ☐ Difficulty chewing
- ☐ Head, neck, or jaw injuries
- ☐ Frequent headaches
- ☐ Clenching or grinding your teeth
- ☐ Dry mouth symptoms
- ☐ Other? _____

What is your level of pain? (0= no pain to 10= worst possible pain)

Currently: _____ At its best: _____ At its worst: _____

What results are you seeking from treatment?

_____

_____

_____

Have you ever had…?

Orthodontic treatment (braces or clear aligners?) _____ ☐ Yes ☐ No
Oral surgery? _____ ☐ Yes ☐ No
Periodontal/gum treatment? _____ ☐ Yes ☐ No
Your teeth adjusted or bite adjusted? _____ ☐ Yes ☐ No
Worn a bite plate, night guard, or any other appliance? _____ ☐ Yes ☐ No
Are you satisfied with the appearance of your teeth? _____ ☐ Yes ☐ No
Have you ever had an upsetting experience in a dental office? _____ ☐ Yes ☐ No
Is there anything about having dental treatment that bothers you? _____ ☐ Yes ☐ No

Please check *all* you have had or have currently:

Cardiovascular System

- ☐ *Heart Attack/Myocardial Infarction (MI)*
- ☐ Angina/Chest pain
- ☐ *Heart disease or heart condition*
- ☐ *Prosthetic cardiac valve or material*
- ☐ *Previous, relapse, or recurrent Infective endocarditis*
- ☐ *Atherosclerotic heart disease*
- ☐ High cholesterol
- ☐ *High blood pressure*
- ☐ Low blood pressure
- ☐ Congestive heart failure/cardiomyopathy
- ☐ Heart murmur
- ☐ Heart defect
- ☐ Rheumatic fever/heart disease
- ☐ Scarlet fever
- ☐ Heart surgery
- ☐ Use a pacemaker or implantable defibrillator
- ☐ Had heart tests
- ☐ Chest pain or arrhythmias
- ☐ Shortness of breath/dyspnea on exertion
- ☐ Shortness of breath while laying down
- ☐ Swollen ankles
- ☐ Cardiac transplant with cardiac valvopathy
- ☐ Abnormal exercise tolerance
- ☐ Congenital heart disease
- ☐ Other heart conditions? _____

Pulmonary

- ☐ *Asthma*
- ☐ Seasonal allergies/sinus trouble/ rhinitis
- ☐ *COPD (emphysema/bronchitis)*
- ☐ *Obstructive sleep apnea*
- ☐ Use a CPAP
- ☐ *Interstitial lung disease/pulmonary fibrosis*
- ☐ Lung or breathing problems
- ☐ Persistent cough (More than 3 weeks)
- ☐ Other lung/pulmonary diseases? _____

Endocrine/Metabolic

- ☐ *Diabetes****
- ☐ *Impaired glycemic control/Insulin resistance*
- ☐ *Metabolic Syndrome*
- ☐ *Obesity*
- ☐ Thyroid disease
- ☐ *Graves' disease*
- ☐ Other endocrine diseases? _____

***If you are diabetic, we do ask that you bring your glucometer to appointments to check your blood glucose before procedures. We do have one available, but there is a charge associated if we need to use ours.

Hematologic

- ☐ Anemia
- ☐ Bleeding disorder, hemophilia, von Willebrand's
- ☐ Leukemia
- ☐ Bruise easily
- ☐ Prolonged/unusual bleeding
- ☐ History of blood clots
- ☐ Had a blood transfusion
- ☐ Other hematologic/blood diseases? _____

Gastrointestinal

- ☐ Stomach or intestinal problems
- ☐ *Liver disease/hepatic disease*
- ☐ *Nonalcoholic Fatty Liver Disease (NAFLD)*
- ☐ Jaundice
- ☐ GERD/acid reflux
- ☐ *Ulcers*
- ☐ *Inflammatory Bowel disease (Crohn's/Ulcerative Colitis)*
- ☐ Other GI Diseases? _____

Cancer or Tumor

- ☐ Treated for cancer or tumor
- ☐ Diagnosed with cancer
- ☐ *Colorectal cancer*
- ☐ *Gastric/esophageal cancer*
- ☐ *Liver or pancreatic cancer*
- ☐ *Lung cancer*
- ☐ *Oral Cancer/Squamous cell carcinoma*
- ☐ Oral Pre-cancerous lesions
- ☐ Had chemotherapy
- ☐ Had head/neck radiation therapy

Integumentary/Connective Tissue

- ☐ *Lupus*
- ☐ Scleroderma
- ☐ Ehlers-Danlos Syndrome
- ☐ *Psoriasis/Psoriatic arthritis*
- ☐ Other skin conditions? _____

Infectious Diseases

- ☐ Tuberculosis
- ☐ HIV/AIDS or STD? _____
- ☐ Hepatitis or Other? _____

Psychiatric/Mental/Emotional Health

- ☐ *Depression/depressive disorders*
- ☐ *Emotional Stress*
- ☐ Any other mental health/psychiatric disorders? Anxiety disorder, OCD, bipolar, etc._____

Musculoskeletal

- ☐ Muscle or bone problems
- ☐ Arthritis
- ☐ *Rheumatoid Arthritis*
- ☐ *Osteoporosis*
- ☐ Osteopenia
- ☐ Facial pain or TMD
- ☐ Fibromyalgia
- ☐ Have a prosthetic joint
- ☐ If so, do you require premedication? _____
- ☐ Any implants? _____
- ☐ Other bone problems/ diseases? _____

Central Nervous System

- ☐ *Cerebral vascular accident/stroke/TIA*
- ☐ Epilepsy/seizure
- ☐ *Alzheimer's/dementia*
- ☐ *Cognitive Decline*
- ☐ *Multiple Sclerosis (MS)*
- ☐ Fainting or dizzy spells
- ☐ Other neurological disease? _____

Kidney

- ☐ *Chronic kidney disease*
- ☐ *Progression of renal disease*
- ☐ Other kidney diseases? _____

Women

Are you pregnant? ☐ Yes ☐ No If so, how many weeks? _____ Due date: _____
Do you anticipate becoming pregnant? _____ ☐ Yes ☐ No
Are you taking birth control medication? _____ ☐ Yes ☐ No Are you nursing? _____ ☐ Yes ☐ No
Have you had any adverse pregnancy outcomes (pre-term, low birth weight, pre-eclampsia, others)?_____ ☐ Yes ☐ No
Are you in: Peri-menopause: ☐ Yes ☐ No Menopause: ☐ Yes ☐ No Post-Menopause: ☐ Yes ☐ No

Medications

☐ Please list or bring a list of prescribed medications to appointment:

_____

_____

_____

_____

☐ Any OTC medications? (If so, please list below): _____

☐ Any vitamins, minerals, or supplements? _____

_____

_____

☐ Any other medications within the past 5 years? _____

_____

☐ Last antibiotic name & date (not including pre-med)? _____

Have you taken steroids in the past 2 years? _____ ☐ Yes ☐ No

Have you ever taken a bisphosphonate (Fosamax, alendronate, Boniva, etc)? _____ ☐ Yes ☐ No

Any other medications for osteoporosis/osteopenia problems? _____ ☐ Yes ☐ No

Have you ever taken a phen-fen/Redux? _____ ☐ Yes ☐ No

Do you require pre-medication? What for? _____ ☐ Yes ☐ No

Additional Medical History

Have you ever had any infertility or adverse reproductive outcomes? _____ ☐ *Yes* ☐ *No*

Have you ever had Sjögren's syndrome or salivary gland problems? _____ ☐ *Yes* ☐ *No*

Do you have Downs Syndrome? _____ ☐ *Yes* ☐ *No*

Have you had a recent weight loss? _____ ☐ Yes ☐ No

Do you have Glaucoma? _____ ☐ Yes ☐ No

Do you have any conditions that would make you immunocompromised? _____ ☐ *Yes* ☐ *No*

If so, please list and explain: _____

Any other conditions, diseases, or problems? _____ ☐ Yes ☐ No

If so, please list and explain: _____

Have you ever been hospitalized? _____ ☐ Yes ☐ No

Have you ever had surgery? _____ ☐ Yes ☐ No

If yes, please list with dates of surgery: _____

Does your family have a history of similar conditions? _____ ☐ Yes ☐ No

If so, please list: _____

Allergies

Please check all medications or substances that have caused an allergic reaction.

- ☐ Anesthetics
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Plastic
- ☐ Sedatives
- ☐ Sulfa

Please describe reaction:

_____

_____

Any other food or medication allergies?

_____

Have you ever had hives or a skin rash? If so, what caused it?_____

Social History

Do you use Tobacco? If so, how much, and for how long? _____ ☐ Yes ☐ No

Do you have a history of tobacco use? If so, when did you quit? _____ ☐ Yes ☐ No

How many packs per day? For how many years? _____ ☐ Yes ☐ No

Do you use alcohol? How often? _____ ☐ Yes ☐ No

History of alcohol use? _____ ☐ Yes ☐ No

Illicit (including marijuana) or prescription drugs not prescribed to you? _____ ☐ Yes ☐ No

Have you ever been treated for substance abuse or alcoholism in the past? _____ ☐ Yes ☐ No

Additional Information

Is there anything else you would like us to know?

_____

_____

_____

Emergency Contact Information

In case of an emergency, please contact (this person will have access to your medical information):

Primary Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Do you want this person to also have access to your financial information? ☐ Yes ☐ No

Secondary Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Do you want this person to also have access to your financial information? ☐ Yes ☐ No

Additional Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Do you want this person to also have access to your financial information? ☐ Yes ☐ No

Consent to Dental Photography

I, _____ (Patient Name), hereby authorize Elkhart Periodontics and Implants, LLC and Dr. Kelly Hill, to take photographs and/or videos of my face, gums, jaws and teeth before, during, and after treatment as part of my dental record.

☐ **I AGREE** to allow the photographs to be used for the following purposes:

- ☐ Dental education including lectures, study clubs, demonstrations, and professional education such as journals or books.
- ☐ Marketing material, including websites, printed materials and patient education.

☐ **I AGREE** and understand if the photographs are used, my name or identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ **I DO NOT AGREE** to have my photographs used for educational or marketing purposes.

I specifically waive any claim for invasion of my personal privacy which might accrue to me on account of the use of such pictures without my express consent in each instance.

I understand I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via mail. The authorization remains in effect unless written notice has been received by Elkhart Periodontics and Implants, LLC.

Signature: _____ Date: _____