# Situate Periodontics, LLC

Dr. Mohamed H. Hassan, BDS, DMD, MS, FICD
Diplomate, American Academy of Periodontology; Fellowship, Temporomandibular Dysfunction
*Practice limited to periodontology, implants, and temporomandibular dysfunction*

Please fill out information for the patient being seen today (All information is kept confidential)

NAME:_____ DOB:_____ Soc. Sec#:_____

ADDRESS:_____
*Street/PO Box #* *Town* *State* *Zip (required)*

CONTACT INFO: _____ _____ _____ _____
*Home Phone #* *Mobil Phone #* *Work Phone #* *E-mail Address*

CHECK APPROPRIATE: _____ _____ _____ _____ _____ _____
*Minor* *Single* *Married* *Divorced* *Widowed* *Separated*

The Following is for insurance purposes. Please fill out information for person who is the **dental insurance subscriber**

DENTAL INSURANCE: _____ _____ _____
*Plan Name* *Subscriber Number* *Group Number*

SUBSCRIBER: _____ _____ _____
*Name* *DOB* *Social Security #*

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____
*Street/PO Box #* *Town* *State* *Zip (required)*

**PATIENT DENTAL HISTORY**

Dentist Name: _____ Date of last dental exam:_____
Dentist Phone :_____ FAX: _____E mail:_____
Dental Practice Address: _____
*Street/PO Box #* *Town* *State* *Zip (required)*

Please answer following questions with appropriate yes/no answer:

Do your gums bleed while brushing or flossing? _____
Are your teeth sensitive to hot/cold liquids or food? _____
Are your teeth sensitive to sweet/sour liquids or food? _____
Do you have any sores or lumps on/near mouth? _____
Have you had any difficult tooth extraction _____
Have you had any prolonged bleeding after extraction? _____

Do you have pain in any of your teeth? _____
Do you have frequent headaches? _____
Do you clench/grind your teeth? _____
Do you bite lips/cheeks frequently? _____
Have you had any:
head, neck or jaw injuries? _____
jaw probs: If yes, when? _____
Pls circle: clicking/pain difficulty chewing difficulty opening/closing jaw

**PATIENT MEDICAL HISTORY**

Physician Name: _____ Date of last physical: _____
Physician Phone: _____ FAX: _____ Email:_____
Practice Address: _____
*Street/PO Box #* *Town* *State* *Zip (required)*

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Please answer following questions with appropriate yes/no answer:

Has there been a change in your health within the last year _____ Are you currently under a physician's care _____
Have you had any serious illness/injury in last 3 years _____ Have you been hospitalized in last 3 years _____

Please circle below, any symptoms you have experienced:

| | | | |
|---|---|---|---|
| Chest pain (angina) | Dizziness | Swollen ankles | Ringing in ears |
| Shortness of breath | Headaches | Recent weight loss | Fever, night sweats |
| Fainting spells | Chronic cough | Bleeding problems | Coughing up blood |
| Blurred vision | Bruise easily | Seizures | Sinus problems |
| Sinus problems | Excessive thirst | Difficulty swallowing | Frequent urination |
| Frequent Diarrhea | Constipation | Blood in stools | Dry mouth |
| Frequent vomiting | Nausea | Jaundice | Difficulty urinating |
| Blood in urine | Joint pain | Joint stiffness | |

Please circle below, any diseases you have now or have had in the past:

| | | | |
|---|---|---|---|
| Heart disease | AIDS | Heart attack | Heart defects |
| Tumors, cancer | Heart murmurs | Arthritis, rheumatism | Rheumatic fever |
| Eye disease | Skin diseases | Stroke | Hardening of arteries |
| High blood pressure | Anemia | Asthma, TB, emphysema | Other lung diseases |
| Syphilis /gonorrhea | Herpes | Hepatitis, other liver disease | Stomach problems/ulcer |
| Kidney/bladder disease | Thyroid disease | Adrenal disease | Prosthetic heart valve |
| Diabetes | Pacemaker | Artificial joint | |

Do you have any allergies to: drugs, foods, medications, latex ? _____
(Please list any and all allergies you have now or have had in the past)

Is there any family history of diabetes, heart problems, tumors? _____

Are you taking prescription medications, over-the-counter medicines? _____

Vitamins/natural remedies? Please list: _____

Please answer following questions with appropriate yes/no answer:

Do you take any recreational drugs _____ Use tobacco in any form _____ Drink alcohol _____
Women Only:
Are you/ could you be pregnant _____ Are you nursing _____ Take birth control _____

Do you have or have you had any other diseases or medical problems NOT listed on this form? If so please explain: