# Gaston Berenguer, D.M.D., M.S.

**Periodontics and Oral Implantology**


**Dental Implants** | **969 S. Federal Hwy., Suite 201** | **Soft Tissue Grafting**
**Bone Grafting** | **Stuart, FL 34994** | **Gum Disease**
**Ridge Augmentation** | **772-288-4444 Fax 772-288-4446** | **Oral & I.V. Sedation**


Date: _____ Your Dentist: _____ Who told you about us? _____
Name: _____ Date of Birth: _____
Address: _____ _____ _____ _____
Street City State Zip
Phone: _____home E-mail_____ Social Security #_____
_____work Emerg. contact name and phone_____
_____cell/pg Employer name_____
Sex: M or F (circle) Height: ____ Weight: ____ Marital Status: ____ Spouse Name: _____
Physician: _____ Secondary Physician: _____

**Present Health**

Please answer all the questions to the best of your ability. Please inform us of any changes in the future including new medications or changes in dosages. Your responses are only for our records and will be kept confidential.

*Please circle appropriate answers, details should be described in comments section:*

Are you under care of a physician?---------- Yes No
Have you ever had any serious illness or operation (heart, RA, cancer, head/neck cancer)?------- Yes No
Have you ever had radiation therapy, chemotherapy or have taken bisphosphanates?---------- Yes No
Are you diagnoses or were diagnosed with Osteoporosis or Osteopenia?---------- Yes No
Are you allergic/sensitive to codeine, aspirin, sulfa, penicillin, novocaine, or any other drug?---- Yes No
Do you have any pain or impairment of your eyes, ears, nose, throat or neck?---------- Yes No
Have you ever tested positive for Tuberculosis(TB) or the Hepatitis or HIV(AIDS) Viruses?----- Yes No
Do you take blood thinners such as Coumadin, Plavix, Pradaxa, Xarelto, Eliquis?---------- Yes No

*Females*

Are you now pregnant, could be pregnant or are anticipating pregnancy?---------- Yes No
Have you undergone or are you presently undergoing menopause?---------- Yes No
Are you taking birth control medications?---------- Yes No

*Please indicate any illness or conditions you have had and write in the year of the illness:*

| | | | |
|---|---|---|---|
| __Heart Disease | __Organ Transplant | __Use illegal drugs/addiction | __Herpes |
| __Heart Attack | __Heart Murmur | __Alcoholism | __Anemia |
| __Stroke | __Joint Replacement | __Epilepsy/Seizure | __Asthma |
| __High Blood Pressure | __Mitral Valve Prolapse | __Skin Condition | __Migraine |
| __Glaucoma | __Rheumatic Fever | __COPD/Shortness of breath | __TMJ |
| __Pacemaker | __Told to take antibiotics | __Eye Condition | __Anxiety |
| __Angina (chest pain) | __Hepatitis/Liver Disease | __Venereal Disease | __Mental |
| __Stents | __Bleed easy or can't stop | __Thyroid Disease | __Allergies |
| __Diabetes | __Bruise easy | __Tuberculosis | __RA, Cancer |
| __Kidney Disease | __Take blood thinners | __Respiratory (lung) | __Osteoporosis/penia |
| __Indwelling Catheter | __Take Aspirin, Fish Oil, Vit E | __Sinus Trouble | __Arthritis |

C**omments**_____
_____

**Intake**

Have you ever smoked (including pipe, cigars)? Yes or No Currently? Yes or No
How many packs per day? _____ How many years? _____Year you quit? _____
Do you use smokeless tobacco? Yes or No How many years? _____
What is your alcohol consumption per week? _____
Please list all medications you are currently taking (prescription, over-the-counter, birth control pills, vitamins, etc.)_____
_____
_____

**Dental History**

*Do you have any of the following? Please indicate and add comments to the side or below.*

__Bleeding gums
__Bad taste or odor in your mouth
__Clicking or pain when opening or closing your jaw
__Generalized or localized pain
__Sensitivity to cold or hot
__Grinding or Clenching

*Have you had any of the following in the past?*

__Gum boils or abscesses
__Braces
__Third molars (wisdom teeth) extractions
__Periodontal Disease (Pyorrhea)
__Periodontal treatment-non surgical (deep cleaning)
__Periodontal treatment-surgical
__TMJ treatment
__Bad experience in a dental office

What do you consider most important? (Rank 1-4)

__Preservation of natural teeth __Elimination of infection
__Elimination of pain __Appearance

*Do you have any other disease or problem that we should know about? Please list below.*

_____

**Comments**_____
_____
_____
_____

I certify that I have provided accurate answers to the best of my knowledge and that I have not withheld any medical information or misled Dr. Gaston Berenguer in any way.

Signature: _____ Date: _____ Reviewed by: _____

Updated: _____ Date: _____ Reviewed by: _____

*Thank you for your cooperation!*