NEIL A. LANDY, D.M.D., M.S.D.

PEMBROKE ONE, SUITE 231
281 INDEPENDENCE BOULEVARD
VIRGINIA BEACH, VIRGINIA 23462

Practice Limited to Periodontics and Implants

(757) 490-3830

(Please complete both sides of form and provide us with any insurance forms.
New exam fee payable at time of service, we will send in your insurance for re-imbursement).

PATIENT'S INFORMATION

Name _____ SS# _____ Date _____

Address _____ City _____ State _____ Zip _____

Marital Status _____ Date of Birth _____ Occupation _____

Employer _____ Bus. Phone _____

Spouse or Parents Name _____ SS# _____

Employer _____ Bus. Phone _____ DOB _____

Person to contact in case of emergency _____ Phone # _____

Referred by _____ Family Dentist _____ Family Physician _____

RESPONSIBLE PARTY

Name of person responsible for account _____ Relationship to patient _____

Address _____ Home Phone _____

Employer _____ SS# _____ Bus. Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# of Insured _____

Employer _____ Bus. Phone _____

Insurance Co. _____ Grp# _____

Other/Secondary Ins. _____ Name of Insured _____ SS# _____ DOB _____

Employer _____ Grp # _____ Bus. Phone _____

MEDICAL AND DENTAL HISTORY

Answers to the following questions are for our records and will be considered confidential.

YES NO

☐ ☐ 1. Are you or have you recently been experiencing pain in your mouth or face?

☐ ☐ 2. Do you have any dental condition which you believe requires immediate attention today?

☐ ☐ 3. Do you consider your general health to be good?
Approximate date of last physical examination
_____

☐ ☐ 4. Are you being treated for any condition by a physician now?
What? _____

☐ ☐ 5. Are you now taking any medicines (drugs or pills)?
Which? _____

☐ ☐ 6. Are you allergic or have you reacted adversely to any of the following?
- ☐ Local anesthetic (novacaine)
- ☐ Penicillin or any other antibiotics
- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Other _____

☐ ☐ 7. Have you ever had a serious illness or operation?

8. Have you ever had any of the following? Please check which one(s)
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Joint Replacement
- ☐ Stroke
- ☐ Congenital Heart Lesions
- ☐ Injury to face or jaws
- ☐ High or low blood pressure
- ☐ Blood transfusion
- ☐ Bleeding problems
- ☐ Ulcers
- ☐ Allergy (Hives or Skin Rash)
- ☐ Convulsions or Epilepsy
- ☐ Arthritis
- ☐ Inflammatory Rheumatism
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Kidney or Bladder trouble
- ☐ Hepatitis or Liver trouble
- ☐ Jaundice
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Lung Trouble
- ☐ X-Ray treatment
- ☐ Asthma
- ☐ Hay Fever
- ☐ Blood Disorder such as Anemia
- ☐ Psychiatric treatment
- ☐ Frequent, severe headaches
- ☐ Cortisone, hydrocortisone, or ACTH
- ☐ AIDS

(OVER)

YES NO

- ☐ ☐ 9. Are you ever short of breath or do you have chest pain on mild exertion?
- ☐ ☐ 10. Do your ankles swell?
- ☐ ☐ 11. Have you ever had painful or swollen joints?
- ☐ ☐ 12. Do you have a persistent cough?
- ☐ ☐ 13. Have you recently gained or lost weight without dieting?
  Which? _____
- ☐ ☐ 14. Have you noticed any recent increased tendency for your skin to bruise?
- ☐ ☐ 15. Are you thirsty and/or hungry most of the time?
  Which? _____
- ☐ ☐ 16. Is there any history of diabetes in your family?
- ☐ ☐ 17. Do you have frequent canker or cold sores?
- ☐ ☐ 18. Do you have a tendency to faint?
- ☐ ☐ 19. Are you wearing contact lenses?

DENTAL HISTORY

20. How frequently do you visit your dentist?
  _____
21. When did you last have your teeth cleaned?
  _____
- ☐ ☐ 22. Have you ever had any teeth extracted?
  Why? _____
  Any associated bleeding or healing problems? _____
- ☐ ☐ 23. Have you ever had orthodontic treatment (teeth straightened)?
24. When were you first made aware that you had periodontal (gum) problems? _____
- ☐ ☐ 25. Have you ever had periodontal (gum) treatment?
  When? _____
- ☐ ☐ 26. Have you ever had endodontic (root canal) treatment?
- ☐ ☐ 27. Do you have any removable bridges? How many years?
  _____
  Is it comfortable? _____
- ☐ ☐ 28. Would you be greatly disturbed if you had to lose all your natural teeth and wear false teeth?
- ☐ ☐ 29. Did either of your parents lose all of their natural teeth?
- ☐ ☐ 30. Are you dissatisfied with the appearance of your teeth?
  Why? _____
- ☐ ☐ 31. Are there any foods you cannot chew?
  Which? _____
- ☐ ☐ 32. Have you noticed any loose teeth?
  Where? _____
- ☐ ☐ 33. Have any of your teeth recently separated, creating spaces between them? Where? _____
- ☐ ☐ 34. Does food wedge between any of your teeth?
  Where? _____
- ☐ ☐ 35. Are your teeth sensitive to cold, heat or sweets?
  Which? _____
  Where? _____
- ☐ ☐ 36. Do your gums ever bleed?
  When? _____

YES NO

- ☐ ☐ 37. Have you noticed any bad odors or tastes from your mouth?
- ☐ ☐ 38. Have you ever had Vincent's infection or trench mouth?
  When? _____
- ☐ ☐ 39. How often do you brush your teeth? _____ times per day
  When? _____
- ☐ ☐ 40. Do you use a hard, medium, or soft bristle brush?
  Which? _____
- ☐ ☐ 41. Do you daily use dental floss, rubber tip or Stimudents?
  Which? _____
- ☐ ☐ 42. Do you use anything else to clean your teeth? If so, what?
  _____
- ☐ ☐ 43. Have you ever had oral hygiene instruction?
- ☐ ☐ 44. Does your jaw click when you chew?
- ☐ ☐ 45. Is it difficult to open your mouth as wide as you would like?
- ☐ ☐ 46. Do you ever have pain in the region in front of your ears?
- ☐ ☐ 47. Do you clench, grit or grind your teeth in the daytime or while you are sleeping?
- ☐ ☐ 48. Do you have any habits, such as biting your nails, chewing on pipe or pencil, etc.? _____
- ☐ ☐ 49. Have you been under more than average nervous tension lately?
- ☐ ☐ 50. Is your mouth dry in the morning when you awaken?
- ☐ ☐ 51. Do you breathe through your mouth much of the time?
- ☐ ☐ 52. Do you smoke? What and how much?
  _____
- ☐ ☐ 53. Is there any health information which was not asked, which you feel may influence dental treament?
  What? _____
  _____
  _____
54. When was the first time you were seen by the referring dentist? _____

WOMEN ONLY

- ☐ ☐ 55. Are you pregnant?
- ☐ ☐ 56. Are you taking birth control pills?
- ☐ ☐ 57. Have you undergone, or are you undergoing menopause?

A service charge of 1.75% per month on the unpaid balance (21% Annual Percentage Rate) will be charged after 30 days.

The undersigned agrees to be financially responsible for cost of all services rendered. I understand that any insurance filing by Dr. Landy's office is done so as a courtesy only. Insurance processing is my responsibility.

In the event that the bill is delinquent, I agree to pay all cost of collections including an attorney's fee of 33 1/3% of the balance referred to the attorney.

_____

Signature Date