Gary G. Cook, DDS

Board Certified
American Board of Periodontology

2718 N. Orange Avenue, Orlando, Florida 32804-4685
Tel: (407) 898-9988 ▼ Fax: (407) 898-3343
Toll Free: 1-877-898-1122
e-mail: DrCook@GaryGCookDDS.com
GaryGCookDDS.com

Patient Information

Name: Ms / Mrs / Mr / Dr _____
First Mi Last

Address: _____
Street City State Zip

Telephone: Home _____ Work _____ Ext. _____ Cell _____

Birth date: _____
Month/Day/Year

Employer: _____

Employer's Address: _____
Street City State Zip

Spouse's Name: _____

Spouse's Employer: _____

Person to call in case of emergency: _____ Telephone: _____

General Dentist's Name: _____ Telephone: _____

Referred to this office by: ❑ General Dentist ❑ Other (Please complete below)

Name: _____

Address: _____
Street City State Zip

Person Responsible for account ❑ Patient (Proceed to next page) ❑ Other (Please complete below)

Name: Ms / Mrs / Mr / Dr _____
First Mi Last

Billing Address: _____
Street City State Zip

Telephone: Home _____ Work _____ Ext. _____ Cell _____

Birth date: _____ SSN: _____
Month/Day/Year

Employer: _____

Employer's Address: _____
Street City State Zip

HEALTH QUESTIONNAIRE

List any allergies _____

How often do you use dental floss? _____

When was the last time you had your teeth cleaned? (mo.yr.) _____

Approximately how long have you been a patient of your general dentist? _____

Describe any dental pain you are having:

_____

_____

Please check the appropriate answer for each of the following:

	Yes	No
Do your gums bleed when you brush your teeth?	___	___
Do you periodically have gum boils or abscesses?	___	___
Do you have difficulty chewing food?	___	___
Do your teeth seem to be shifting in position?	___	___
Do you grind your teeth at night?	___	___
Have dental implants been recommended for you by your dentist?	___	___
Have you worn braces for straightening your teeth? (When _____)	___	___
Do you chew or smoke tobacco? (_____ packs/day) If so, for how long? _____	___	___
Have you ever had surgery or radiation treatment to your head or neck for a tumor?	___	___
Do you have a disease or condition that might compromise your immune system?	___	___
Has there been any change in your general health within the last year?	___	___

Females:

Are you taking birth control pills?	___	___
Are you or might you be pregnant?	___	___

Check any of the following which you may have had:

- ❑ Heart Valve Prosthesis *
- ❑ Joint Replacement *
- ❑ Alcoholism
- ❑ Asthma
- ❑ Cancer
- ❑ Cardiac Pacemaker
- ❑ COPD
- ❑ Diabetes Type ❑ **I** ❑ **II**
  If diabetic, what was your last HgbA1C? _____
- ❑ Epilepsy
- ❑ Heart Surgery
- ❑ Hepatitis ❑ A ❑ B ❑ C
- ❑ High Blood Pressure
- ❑ HIV
- ❑ Kidney Disease
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Ulcers

* Have you been directed to take antibiotics prior to having your teeth cleaned due to any of the above medical conditions?

❑ Yes ❑ No

Please list the medications which you have been directed NOT to take (e.g. NSAIDS, Aspirin, etc.) _____

_____

Please describe any disease, condition or problem not previously listed: _____

List any medications you are currently taking, **including vitamins and aspirin:**

_____ dosage _____

_____ dosage _____

_____ dosage _____

_____ dosage _____

_____ dosage _____

Dental Insurance Information

Primary Insurance Company: _____

Address: _____
Street City State Zip

Group or Policy Number: _____

Telephone: _____ Insurance Contact Name: _____

Effective Date: _____ Payor ID: _____

Relationship of Patient to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Policyholder's Name: _____

Telephone: _____ Ext. _____ Birth date: _____
Month/Day/Year

SSN or Employee ID Number: _____

Do you have secondary dental insurance? ❑ Yes ❑ No

If Yes, name of insurance carrier: _____

I understand that I am financially responsible for all fees whether or not paid by my insurance company. I authorize release of information to my insurance company when required to file a claim.

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE