coastal periodontics
Your Smile, Your Health, Our Mission

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Date: ____/____/____

Patient name:

Are you taking any blood thinners:

YES or NO If Yes, What is the name?

Prescribing Dr. and phone number:

List of Medication:

List any over the counter Vitamins:

PERIO QUESTIONS:

When was your last regular cleaning?

Have you ever had a deep cleaning?

YES or NO If Yes, What is the name?

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Perio Maintenance frequency?

3 MONTHS 4 MONTHS 6 MONTHS

Do you wear a night guard?

YES OR NO

Tooth brush type?

SOFT MEDIUM HARD

ELECTRIC:

SONICARE ORAL B

How many times a day do you brush?

1X 2X 3X INFREQUENTLY

Flossing?

PICKS WATER PICK FLOSS SUPER FLOSS

How many times a day do you floss?

1X 2X 3X INFREQUENTLY

Bleeding gums?

YES OR NO

Bad breath?

YES OR NO

Do you grind your teeth?

YES OR NO

Sensitive teeth?

YES OR NO

Concern with smile?

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