

8686 131st St. N.
Seminole, FL 33776



727-605-5775

Patient Information

Title: _____	Nickname: _____	Birth Date: _____	Age: _____
Last, First: _____	Marital Status: _____	Sex: _____	
Address: _____	Cell #: _____	Work #: _____	
_____	Home #: _____	Driver License #: _____	
City, State, Zip: _____	Emergency Contact: _____	Emergency Phone #: _____	
Email: _____	Student: _____	SSN: _____	
Health Care Guardian Name: _____	School Name: _____		
Health Care Guardian Phone #: _____	Referral Type: _____		

Person responsible/guarantor for paying bill

Title: _____	Nickname: _____	Birth Date: _____	Age: _____
Last, First: _____	Marital Status: _____	Sex: _____	
Address: _____	Cell #: _____	Work #: _____	
_____	Home #: _____	Drive License #: _____	
City, State, Zip: _____	SSN: _____		
Email: _____			

Primary Dental Insurance

Group No/Name: _____
Insurance Name: _____
Phone #: _____
Employer Name: _____
Subscriber Last, First: _____
Subscriber Address: _____
City, State, Zip: _____
Relationship to Patient: _____
Subscriber ID: _____ Birth Date: _____

Secondary Dental Insurance

Group No/Name: _____
Insurance Name: _____
Phone #: _____
Employer Name: _____
Subscriber Last, First: _____
Subscriber Address: _____
City, State, Zip: _____
Relationship to Patient: _____
Subscriber ID: _____ Birth Date: _____

Patient Medical Information

Please circle only if YES

Allergic To

- | | | | | | |
|-----|--------------------|-----|-------------------|-----|--------------------|
| Y N | No known Allergies | Y N | Amoxicillin | Y N | Metals |
| Y N | Aspirin | Y N | Hydrocodone | Y N | Red or Blue Dye |
| Y N | Penicillin | Y N | Latex Rubber | Y N | Sulfa Drugs |
| Y N | Codeine | Y N | Epinephrine | Y N | Seasonal Allergies |
| Y N | Erythromycin | Y N | Local Anesthetics | Y N | Other Allergies |

Circle, if applicable

- | | | | | | |
|-----|-------------------------------|-----|-------------------------|-----|------------------------------|
| Y N | Abnormal/Excessive Bleeding | Y N | Congenital Heart Defect | Y N | Kidney Disease |
| Y N | Acid Reflux/GERD | Y N | Delayed Development | Y N | Leukemia |
| Y N | ADD/ADHD | Y N | Dementia/Alzheimers | Y N | Liver Disease |
| Y N | AIDS/HIV Infection | Y N | Diabetes Type 1 | Y N | Low Blood Pressure |
| Y N | Alcohol/Drug Abuse | Y N | Diabetes Type 2 | Y N | Lupus |
| Y N | Angina/Chest Pain | Y N | Downs Syndrome | Y N | Mental Health Problems |
| Y N | Anemia | Y N | Eating Disorders | Y N | Mitral Valve Prolapse |
| Y N | Antibiotic Premedication | Y N | Epilepsy/Seizures | Y N | MTHFR |
| Y N | Anxiety | Y N | Failure to Thrive | Y N | Radiation Treatment |
| Y N | Artificial Joints/Replacement | Y N | Fainting Spells | Y N | Rheumatic Fever |
| Y N | Arthritis | Y N | Fever Blisters | Y N | Rheumatic Heart Disease |
| Y N | Asthma | Y N | Frequent Headaches | Y N | Sensory Disorders |
| Y N | Autism | Y N | G-Tube | Y N | Sexually Transmitted Disease |
| Y N | Autoimmune Disease | Y N | Gag Reflex | Y N | Sinus Problems |
| Y N | Blood Clotting Problems | Y N | Glaucoma | Y N | Sjogren Syndrome |
| Y N | Blood Disease | Y N | Hearing Impairment | Y N | Stomach Problems |
| Y N | Brain Stents | Y N | Heart Attack | Y N | Stomach Ulcers |
| Y N | Brain Surgery | Y N | Heart Disease | Y N | Stroke |
| Y N | Breathing/Respiratory Issues | Y N | Heart Murmur | Y N | Thyroid Problems |
| Y N | Cancer | Y N | Heart Stens | Y N | Tuberculosis |
| Y N | Cardiac Pacemaker | Y N | Heart Valve Replacement | Y N | Tumors/Growths |
| Y N | Cerebral Palsy | Y N | Hepatitis | Y N | Vision Impairment |
| Y N | Chemotherapy | Y N | Prior Hepatitis | | |
| Y N | Cleft Palate | Y N | High Blood Pressure | | |

Additional Comments: _____

Dental Questionnaire

Name of the person filling out this form: _____
Relationship to the patient: _____

Name of the patient's previous dentist and office phone number: _____
Date of the patient's last cleaning and exam: _____
Date of the patient's last full series of Panoramic x-rays: _____
Date of the patient's last cavity detection (bitewing) x-rays: _____
What is the purpose for the patient's visit today? _____
Does the patient regularly use dental floss? _____
How many times a day for the patient brush? _____
Does the patient's gums bleed while brushing or flossing? Y N
Are the patients teeth sensitive to hot, cold or sweets? Y N
Does food catch between the patient's teeth? Y N
Does the patient have unpleasant taste or odor in their teeth/mouth? Y N
Does the patient notice popping, clicking or soreness of the jaws or joints? Y N
Does the patient clench or grind their teeth? Y N
Does the patient ever have difficulty in opening their mouth widely? Y N
Has the patient ever had orthodontic treatment? If yes, when? Y N
What, if anything, would the patient like to improve about their smile? Y N

CHILDREN ONLY

Is the patient's water fluoridated? Y N
Does the patient take fluoride supplements? Y N
Does the patient have speech problems? Y N
Does the patient have or had any of these habits? Y N

ADULTS ONLY

Does the patient have, or have they ever been told, they have Periodontal Disease? Y N
Has the patient has any periodontal therapy such as deep cleanings or surgery? Y N
If yes, what & when? _____
Does the patient have any loose teeth Y N
Does the patient have missing teeth they would like replaced? Y N
Does the patient wear dentures or partials? If yes, are they happy with them? Y N

ADDITIONAL COMMENTS: _____

Medical Questionnaire

Name of the person filling out this form: _____
Relationship to the patient: _____

Patient's physician name: _____
Phone number: _____
Date of the patient's last physical exam: _____
Preferred pharmacy's name and number: _____
Is the patient currently under the care of a Physician? _____
If yes, what is the condition being treated? _____
Specialist Physician names and phone numbers, if applicable: _____

Has the patient had any serious illness, operation or been hospitalized in the past 5 years? Explain **Y N**

Please list all medications and over the counter supplements the patient is currently taking: _____
Does the patient use alcoholic beverages? If yes, how often? _____

Does the patient smoke, dip or chew tobacco? If yes, how much per day? _____
Ever taken bisphosphonates? **Y N**

(Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)

WOMEN ONLY

Are you pregnant? **Y N**
If yes, what is your due date? _____

Are you currently nursing? **Y N**

Are you on hormone replacement therapy? **Y N**

Are you on birth control pills/fertility drugs? **Y N**

ADDITIONAL COMMENTS

Any disease, allergy, conditions or problem not listed? Please list: _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfactions. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of these forms.

Parent/Guardian's Signature

Date