

727 3rd St.
Winter Haven, FL 33880



863-282-2053

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: _____

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Patient Medical Information

Please circle YES or NO

Allergic To: Circle Y or N

Y N	Any 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 Y or N

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 Deficiency
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	See's a Specialist Physician
Y N	Cleft Palate	Y N	High Blood Pressure		

Additional Comments: _____

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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

Circle if the patient has or has previously had any of these habits?
None Known Thumb/Finger Sucking Pacifier Bottle Tongue Thrust Nail Biting Chewing Inanimate Objects Other

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: _____

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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: _____

DOCTOR'S COMMENTS:

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