5456 Spring Hill Dr.
Spring Hill, FL 34684

palm tree DENTISTRY

352-666-1400

Patient Information

Title: _____ Nickname: _____
Last, First: _____
Address: _____
_____
City, State, Zip: _____
Email: _____
Health Care Guardian Name: _____
Health Care Guardian Phone #: _____

Birth Date: _____
Marital Status: _____
Cell #: _____
Home #: _____
Emergency Contact: _____
Student: _____
School Name: _____
Referral Type: _____

Age: _____
Sex: _____
Work #: _____
Driver License #: _____
Emergency Phone #: _____
SSN: _____

Person responsible/guarantor for paying bill

Title: _____ Nickname: _____
Last, First: _____
Address: _____
_____
City, State, Zip: _____
Email: _____

Birth Date: _____
Marital Status: _____
Cell #: _____
Home #: _____
SSN: _____

Age: _____
Sex: _____
Work #: _____
Drive License #: _____

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	Diabeted 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 Ulsers
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, Reciast*)

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