

107 W. Robertson St.  
Brandon, FL 33511



813-685-0804

### 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 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## 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