How were you referred?

Allow us to thank the person who referred you.
Please fill in the appropriate blanks below.

	Print ads in mailbox	**REF CODE**
☐	The Flyer – Dental Offer	9850100
☐	The Flyer – Implant	9850100
☐	Val Pak	9850100
	Internet	
☐	Google Search	9850010
☐	Yahoo Search	9850010
☐	Yellow Pages – Online	9850140
☐	Groupon	9850060
☐	Living Social	9850060
	Other	
☐	New Beauty Magazine	9850100
☐	Yellow Pages – Book	9850140
☐	Another Patient Patient Name: ____	
☐	Walk In	9850050

Medical History

Patient Name: ______________________________ Birth Date: ____________________

Although dental personnel treat the area in and round your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, Could have an interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? □ No □ Yes ______________________________
Have you ever been hospitalized or had a major operation? □ No □ Yes ______________________________
Have you ever had a serious head or neck injury? □ No □ Yes ______________________________
Are you taking any medication, pills, or drugs? □ No □ Yes ______________________________
Do you take, or have you taken, Phen-Fen o Redux? □ No □ Yes ______________________________
Are you on a special diet? □ No □ Yes ______________________________

Do you use tobacco? □ No □ Yes Do you use controlled substances? □ No □ Yes

Women: □ Pregnant/trying to get pregnant □ Taking oral contraceptives □ Breastfeeding

Are you allergic to any of the following?
□ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal □ Latex □ Sulfa drugs
□ other allergies: ____

Do you have, or have you had, any of the following? (Please check all that apply)

☐ AIDS/HIV Positive	☐ Diabetes	☐ Hepatitis B or C	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Drug Addiction	☐ Herpes	☐ Rheumatism
☐ Anaphylaxis	☐ Easily Winded	☐ High Blood Pressure	☐ Scarlet Fever
☐ Anemia	☐ Emphysema	☐ High Cholesterol	☐ Shingles
☐ Angina	☐ Epilepsy/Seizures	☐ Hives/Rash	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Artificial Joint	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Frequent Cough	☐ Leukemia	☐ Stroke
☐ Blood Disease	☐ Frequent Diarrhea	☐ Liver Disease	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Breathing Problem	☐ Genital Herpes	☐ Lung Disease	☐ Tonsillitis
☐ Bruise Easily	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Cancer	☐ Hay Fever	☐ Osteoporosis	☐ Tumors/Growths
☐ Chemotherapy	☐ Heart Attack/Failure	☐ Pain In Jaw Joints	☐ Ulcers
☐ Chest Pains	☐ Heart Murmur	☐ Parathyroid Disease	☐ Venereal Disease
☐ Colds Sores/Fever blisters	☐ Heart Pacemaker	☐ Psychiatric Care	☐ Yellow Jaundice
☐ Congenital Heart Disorder	☐ Heart Trouble/Disease	☐ Radiation Treatments	
☐ Convulsions	☐ Hemophilia	☐ Recent Weight Loss	
☐ Cortisone Medicine	☐ Hepatitis A	☐ Renal Dialysis	

Have you ever had any serious illness not listed above? □ No □ Yes ______________________________

Comments: ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature: ____ Date: ____________________

Family Dentistry & Orthodontics
Miami Center for Cosmetic and Implant Dentistry

Patient Initial Chart

Last Name: ______________________________ First Name: ___________________________ Middle Initial: _________

Date of Birth: ____________________ Social Security#: ______________________ Dental Insurance: ____________________

Cell Ph: ____________________ Home Ph: ____________________ E-mail: _______________________________________

Address: ____ City, State, Zip: _______________________________

Driver License #: ____ State: __________________

Sex: __________ Height: __________ Weight: __________

Name of Physician: __________________________ Physician's Phone #: ____________________

Occupation: ____________________ Employer: ___________________________ Work Ph: ____________________

Marital Status: _______________ Spouse's Name: ______________________________

- How did you hear about our office? ____
- Reason for visit? ____
- When was your last dental visit? ____
- Have you ever had any serious complications associated with previous dental treatment? Explain:

  ____
- How often do you brush your teeth? : ____________________ Floss? : ____________________
- What texture toothbrush do you use? : ❑ Soft ❑Medium ❑Hard ❑Nylon
- Do your gums bleed when: ❑ Brushing ❑ Flossing
- Do you feel discomfort when your teeth come in contact with liquids or foods that are hot, cold, sour, or sweet?

  ❑ No ❑ Yes: Explain ____
- Do you have: ❑ Dentures ❑ Fillings ❑ Missing Teeth ❑ Loose Teeth If so, Explain: _____________________________

  ____
- Do your gums feel tender or swollen? ❑ No ❑ Yes ____
- Do you gag easily? ❑ No ❑ Yes
- Do you clench or grind your jaws? ❑ No ❑ Yes

I am interested in: Please check all that apply

❑ Whiter Teeth
❑ Replacing missing teeth
❑ Fixing broken or fractured teeth
❑ Extracting wisdom teeth
❑ Eliminating Pain / Discomfort
❑ A better smile
❑ Straightening my teeth
❑ Healthier gums
❑ A better bite
❑ A healthy mouth
❑ Other:

____

____

Consent for treatment

This is to ceritify that I, the undergined, consent to the performing of dental and oral surgical precedures agreed to be necessart or advisable, including local anesthetic, as indicated. Family Dentistry & Orthodontics may review my credit history in order to help in providing me with the most convenient financial arrangement. I will assume responsibility for fees associated with dental procedures I agree to.

⇨ ____ ____________________

Patients Signature Date

Patient Consent to receive Mail, E-mail and/or Telephone Messages

____

Last Name First Name Middle Initial

I agree that the practice may communicate with me electronically at the following address:

E-Mail Address ____

Please provide us with the best phone number(s) to reach you:

_______________________ ☐ Cell / ☐ Home

_______________________ ☐ Work / ☐ Home

_______________________ ☐ Other________________

Do we have your permission to:

Send an appointment reminder post card to your home? ☐ Yes ☐ No

Leave voice mails or send e-mails in regards to account and appointment information? ☐ Yes ☐ No

I give permission to share appointment, billing, or dental information with the person named below:

____ Name

______________________ Relation

____ Signature of Patient

____________________ Date

Acknowledgment of Receipt of Notice of Privacy Practices

Please see attached form titled *HIPAA* before signing

I, __________________________________ have received a copy of this office's Notice of Privacy Practices.

Print full name

____ Signature of Patient

____________________ Date