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