

# Welcome to our Practice!

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Plantation Dental Associates

Please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health or medications, please tell us. If you have any questions, do not hesitate to ask.

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

How do you prefer to be contacted? \_\_\_\_\_

Drivers License #: \_\_\_\_\_ State: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Spouse's Name & Phone #: \_\_\_\_\_

In the event of an emergency, is there someone you prefer we contact? \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## PRIMARY INSURANCE

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Group#: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

## SECONDARY INSURANCE

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Group#: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

**Please see next page**

# MEDICAL HISTORY

Name of your medical doctor: \_\_\_\_\_ Date of last visit to medical doctor: \_\_\_\_\_

Name of your last dentist: \_\_\_\_\_ Date of last visit to dentist: \_\_\_\_\_

	Yes	No		Yes	No
<b>Heart Problems</b> .....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells, seizures or epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke(s).....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough or swollen glands.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Premedications required by physician.....	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Urine more than 6 times a day.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>	Thirsty or mouth is dry much of the time...	<input type="checkbox"/>	<input type="checkbox"/>
<b>Blood Problems</b> .....	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or other respiratory disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?.....	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Drinks per day? _____		
Blood disease (anemia).....	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?.....	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day? _____		
<b>Allergy Problems</b> .....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Herpes or other STD.....	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems.....	<input type="checkbox"/>	<input type="checkbox"/>	HIV-positive/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	History of head injury.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Intestinal Problems</b> .....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or other neurological disease?.....	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	History of alcohol or drug abuse?.....	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease condition, or problem		
Special Diet.....	<input type="checkbox"/>	<input type="checkbox"/>	not listed previously that you feel we should know		
Constipation/Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	about?.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems.....	<input type="checkbox"/>	<input type="checkbox"/>	If so, please describe: _____		
<b>Bone or Joint Problems</b> .....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Back or neck pain.....	<input type="checkbox"/>	<input type="checkbox"/>			
Joint replacement.....	<input type="checkbox"/>	<input type="checkbox"/>			
(e.g., total hip, pins or implants)					

## MEDICAL HISTORY (CONTINUED)

**During the past 12 months, have you taken any of the following?**

	Yes	No		Yes	No
Antibiotics or sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking any prescription/over the		
Anticoagulants (e.g. Coumadin).....	<input type="checkbox"/>	<input type="checkbox"/>	counter drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine.....	<input type="checkbox"/>	<input type="checkbox"/>	If so, list each one (name, dosage, amount per day)		
Tranquilizers.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Insulin, Orinase, or similar drug.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Asprin.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Digitalis or drugs for heart trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Nitroglycerin.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cortisone (steroids).....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Natural remedies.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Nonprescription drug/supplements.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		

**Have you ever been diagnosed with sleep apnea?**

If so, do you have a CPAP?

**Are you allergic, or have you reacted adversely, to any of the following?**

	Yes	No		Yes	No
Local anesthetics ("Novocaine").....	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to metals.....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Latex or rubber dam.....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	List any other allergies here:		
Barbiturates, sedatives, or sleeping pills.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Asprin, Acetaminophen, or Ibuprofen.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Codeine, Demerol, or other narcotics.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		

### Women

	Yes	No		Yes	No
Are you taking contraceptives or other hormones?.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you reached menopause?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date:_____			If so, do you have any symptoms? _____		
			_____		
			_____		

# DENTAL HISTORY

Please answer the questions below:

	Yes	No		Yes	No
			Do you clench or grind your jaws frequently?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Do your jaws ever feel tired?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw get stuck so that you can't open it freely?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily?.....	<input type="checkbox"/>	<input type="checkbox"/>	Does it hurt when you chew or open wide to take a bite?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches / pain in front of your ears?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any jaw symptoms or headaches upon awakening in the morning?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty chewing food?.....	<input type="checkbox"/>	<input type="checkbox"/>	Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you take medications or pills for pain or discomfort (pain relievers, muscle, relaxants, antidepressants)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing part of your mouth because of pain?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a temporomandibular (jaw) disorder (TMJ)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain in the face, cheeks, jaws, joints, throat or temples?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss?.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you unable to open your mouth wide?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender?.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of an uncomfortable bite?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed slow-healing sores in or around your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a blow to the jaw (trauma)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?.....	<input type="checkbox"/>	<input type="checkbox"/>	Type of toothbrush bristles?		
Do you feel spurts of pain when your teeth come in contact with:			<input type="checkbox"/> Hard <input type="checkbox"/> Medium <input type="checkbox"/> Soft		
Hot foods or liquids?.....	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? _____		
Cold foods or liquids?.....	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? _____		
Sours?.....	<input type="checkbox"/>	<input type="checkbox"/>	When was your last dental visit? _____		
Sweets?.....	<input type="checkbox"/>	<input type="checkbox"/>			
Do you take fluoride supplements?.....	<input type="checkbox"/>	<input type="checkbox"/>			
Are you dissatisfied with the appearance of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>			
Do you prefer to save your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>			
Does your jaw make noise?.....	<input type="checkbox"/>	<input type="checkbox"/>			

# AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance with \_\_\_\_\_ and assign directly to

Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

**Payment is due in full at time of treatment unless prior arrangements have been approved.**