Welcome to our Practice!

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Charles T. Hopkins, III, D.M.D.
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 Dental Insurance

Insurance Company Name:____

Insurance Company Address:_________________________________ Phone#:_________________

Group#:_________________ Insured's Name: ____

Relationship:___________________ Insured's Birthdate:__________ Insured's SS#: _____________

Insured's Employer:____

Secondary Dental 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
Heart Problems	☐	☐
Chest Pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special Diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins or implants)	☐	☐

	Yes	No
Fainting spells, seizures or epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time...	☐	☐
Abnormal bleeding	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
Drinks per day?_____________________		
Do you smoke?	☐	☐
Packs per day?_____________________		
Hepatitis, jaundice or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses	☐	☐
History of head injury	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you have any disease condition, or problem not listed previously that you feel we should know about?	☐	☐

If so, please describe: _______________

____

____

Medical History (Continued)

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

	Yes	No
Antibiotics or sulfa drugs................................	☐	☐
Anticoagulants (e.g. Coumadin).....................	☐	☐
High blood pressure medicine........................	☐	☐
Tranquilizers..	☐	☐
Insulin, Orinase, or similar drug......................	☐	☐
Aspirin..	☐	☐
Digitalis or drugs for heart trouble...................	☐	☐
Nitroglycerin..	☐	☐
Cortisone (steroids).......................................	☐	☐
Natural remedies...	☐	☐
Nonprescription drug/supplements.................	☐	☐

	Yes	No
Are you taking any prescription/over the counter drugs?...	☐	☐

If so, list each one (name, dosage, amount per day)

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____

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____

____

____

____

Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No

If so, do you have a CPAP? ☐ Yes ☐ No

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

	Yes	No
Local anesthetics ("Novocaine").........................	☐	☐
Penicillin or other antibiotics..............................	☐	☐
Sulfa drugs...	☐	☐
Barbiturates, sedatives, or sleeping pills.............	☐	☐
Aspirin, Acetaminophen, or Ibuprofen..................	☐	☐
Codeine, Demerol, or other narcotics.................	☐	☐

	Yes	No
Reaction to metals.......................................	☐	☐
Latex or rubber dam....................................	☐	☐

List any other allergies here:

____

____

____

Women

	Yes	No
Are you taking contraceptives or other hormones?...	☐	☐
Are you pregnant?..	☐	☐

If so, expected delivery date:___________

	Yes	No
Are you nursing?..	☐	☐
Have you reached menopause?.........................	☐	☐

If so, do you have any symptoms? ____________________

____

____

Dental History

Please answer the questions below:

Question	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you noticed slow-healing sores in or around your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel spurts of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Does your jaw make noise?	☐	☐

Question	Yes	No
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can’t open it freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches / pain in front of your ears?	☐	☐
Do you have any jaw symptoms or headaches upon awakening in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle, relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMJ)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat or temples?	☐	☐
Are you unable to open your mouth wide?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐

Type of toothbrush bristles?

☐ Hard ☐ Medium ☐ Soft

How often do you brush?____________________

How often do you floss?____________________

When was your last dental visit?________________

PATIENT CERTIFICATION & AUTHORIZATION

I certify that I have completed this Medical History Form and that the information provided is true, complete, and accurate to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to my medical history, medications, health status, or insurance information.

I authorize Dr. Charles T. Hopkins III and authorized members of his staff to use and disclose my health information as necessary for treatment, payment, healthcare operations, and insurance claim processing. I authorize the release of any information required to process insurance claims and determine benefits, and I authorize the use of my signature on all insurance submissions, whether submitted electronically or otherwise.

This authorization shall remain in effect until revoked by me in writing. Any written revocation will not apply to actions taken prior to the receipt of such revocation.

By signing below, I acknowledge that I have read, understand, and agree to the above statements.

______________________________________ ____________________

Signature of Patient, Parent, Guardian or Personal Representative Date

______________________________________ ____________________

Please print name of Patient, Parent, Guardian or Personal Representitive Relationship to Patient

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