

Patient Information

Date: _____

Patient's Name: Dr. Mr. Mrs. Ms. Miss _____
(Please circle one) Last First Middle Nickname

Patient's Parent or Legal Guardian: _____
Last First Middle Relationship

Date of Birth: _____ Social Security #: _____ Sex: _____ Marital Status: S M D W

Home Address: _____ City: _____ State: _____ Zip: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Name of School (if student): _____ Grade: _____

Occupation: _____ E-mail Address: _____

Home Phone: _____ Business Phone: _____ Cellular / Pager: _____

Name of Spouse: _____ Occupation: _____ Phone: _____

Names & Ages of Children: _____

Whom may we thank for referring you to our office: _____

Name of emergency contact not living with patient: _____ Phone: _____

Patient's Hobbies and/or Musical Instruments: _____

If not the patient, name and phone number of person responsible for the patient's account:

Name: _____ Phone: _____ Relationship: _____

Dental Insurance Information

Insured Party: _____

Relation to patient: _____ Date of Birth: _____ Social Security #: _____

Insurance Company Name: _____ Insurance Company Phone: _____

Group Number: _____ Group Name: _____ I.D. Number: _____



Pinecrest Dental • Medical Health History

Patient Name: _____ Date: _____

General Health (please check): Excellent Good Fair Poor

Do you have or have you ever had (please check):

- | | | | | | |
|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| Heart Disease..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Cancer | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Rheumatic Fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> | X-ray Treatments for Cancer | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Arrhythmia..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Chemotherapy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Abnormal Heart..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Anxiety or Psychosis..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Bacterial Endocarditis..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unintentional Weight Loss/Gain | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart Valve Replacement..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Eating Disorder..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Thyroid or Endocrine Disorder..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Immune System Disorder..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Artificial Joint Replacement..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | AIDS or HIV Positive..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Chest Pain or Shortness of Breath..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Sexually Transmitted Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Swollen Ankles..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Hepatitis..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Chronic Fatigue or Tire Easily..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Jaundice..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Lymph Node Enlargement or Swollen Glands | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Kidney or Liver Disease..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Severe or Frequent Headaches..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Abnormal Bleeding from a cut..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fainting, Seizures or Dizziness..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Blood Disease or Hemophilia..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Stroke..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Anemia..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Persistent Cough..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Excessive Urination and/or Thirst..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Emphysema | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Diabetes..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Tuberculosis or Lung Disease..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Rheumatoid or Arthritic Condition | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Frequent Colds or Sore Throat | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Osteoporosis..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Asthma or Hay Fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Ulcers or Gastric Reflux..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sinus Trouble | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Epilepsy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Eye, Ear, Nose or Throat Disorder..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Glaucoma..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Drug or Alcohol Addiction..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Abnormal Blood Pressure... High <input type="checkbox"/> Low <input type="checkbox"/> | No <input type="checkbox"/> | No <input type="checkbox"/> |
| Headaches or Migraines | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |

Physician's Name: _____ Telephone number: _____ Date of last physical: _____

- Do you smoke or chew tobacco? Yes No . If yes, how much: _____
- Do you consume alcohol? Yes No . If yes, how much: _____
- Do you use recreational drugs? Yes No . If yes, which drugs: _____
- Are you taking any medication now? Yes No . If yes, names of medications and problems for which they are taken:

Medication (1) _____ Taken for: _____ (3) _____ for: _____

(2) _____ Taken for: _____ (4) _____ for: _____

For Women:

- Are you pregnant? Yes No . If yes, expected delivery date: _____
- Have you reached menopause? Yes No . Are you on Hormone Replacement Therapy? Yes No

Are you allergic or have you had a reaction to:

- a. Local anesthetics..... Yes No
- b. Penicillin or other antibiotics..... Yes No
- c. Aspirin, Ibuprofen or Tylenol..... Yes No
- d. Codeine, Valium or other sedatives..... Yes No
- e. Latex or Metals..... Yes No
- f. Other (please specify) _____

Abnormal Blood Pressure? (Please circle)

Have you ever received a diagnosis of "high blood pressure"? Yes No

What is your normal blood pressure? S /D For office use only: Today: _____

Pinecrest Dental • Medical Health History

Are you taking any of these medications?

- Pre-medication before dental treatment?..... Yes No
- Antacids?..... Yes No
- Dilantin® or Tegretol®..... Yes No
- Barbiturates (any)..... Yes No
- St. John's Wort or Kava-Kava?..... Yes No
- Tagamet® (cimetidine) or Prilosec® (omeprazole)?..... Yes No
- Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?..... Yes No
- Serzone® (nefazodone)..... Yes No
- Diflucan® (fluconazole) or Sporonox® (itraconazole)..... Yes No
- Biaxin® (clarithromycin)..... Yes No
- Have you been treated with Bisphosphonate drugs
(Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)?..... Yes No
- If so, when did the treatment begin? _____ When did the treatment end? _____
- Have you ever taken any prescription drugs such as fen-phen for weight loss?..... Yes No
- Do you consume grapefruit juice, grapefruits or grapefruit extract?..... Yes No

Weight and Diet considerations

Weight	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): <i>none slight moderate high</i>		

Other Physical Problems or Symptoms: _____

Operations or Surgical Procedures: _____

Hospitalizations: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name) Patient/Guardian Signature Date

Doctor (Print Name) Doctor Signature Date

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Consent For Use & Disclosure of Health Information Notice of Privacy Practices Acknowledgement

Please Read The Following Statements Carefully:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Jessenia Mayoral

Office: 305-255-7722 Fax: 305-255-2152 E-mail: smile@pinecrestdental.com

Address: 12651 S. Dixie Hwy., Suite 400, Pinecrest, FL 33156

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Please Print Name, Sign & Date

I _____ have had full opportunity to receive, read and understand the contents of this Consent form and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Signature: _____ **Date:** _____

If a legal guardian on behalf of the patient signs this consent, complete the following:

Legal Guardian's Name: _____

Relationship to Patient: _____



center for cosmetic & family dentistry



RECORDS RELEASE REQUEST

DATE: _____

TO: _____
Previous dentist name / Phone number / Fax number or e-mail address

PATIENT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred electronically* (preferred) or via regular mail promptly to:

**Pinecrest Dental Center for Cosmetic and Family Dentistry
Drs. Kenward and Mayoral
12651 South Dixie Highway, Suite 400
Pinecrest, FL 33156
(305) 255-7722 / (305) 255-2152 Fax
e-mail: Smile@Pinecrestdental.com**

*Please send x-rays in Dexis (preferred), JPEG, or .PDF format.

Print name of patient

Signature (patient, parent or guardian)

DATE