

# 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:

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# 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