

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: _____

Dental Health History

Reason for visit: _____ Approximate date of last dental visit: _____

What is your *primary* concern that you would like us to address first? _____

Have you ever had any serious problem associated with previous dental treatment? Yes No

Is so, explain: _____

What, if anything, has happened in previous experiences at the dentist, that was reason not to return? _____

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

- | | | | | | |
|--|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| Missing Teeth | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Frequent Dry Mouth | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Extra Teeth (<i>Supernumerary</i>)..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Injury to Face or Jaw..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Crooked or Poorly Spaced Teeth..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Wisdom Teeth Problems..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Braces (<i>Orthodontics</i>)..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Pain in Jaw Joints or Facial Muscles | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Chipped or Injured Teeth..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Tooth Grinding or Jaw Clenching..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Root Canal Treatment (<i>Endodontics</i>)..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Jaw Clicking, Popping or Locking | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Broken, Loose or Missing Fillings..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Difficulty in Opening Jaw or Chewing..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Frequent Cavities..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Wear Nightguard or Bite Plate..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Food Trapping Between Teeth..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Fluoridated Water Consumed at Home | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Frequent Canker or Cold Sores..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Fluoride by Prescription (<i>Home</i>) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Tender, Swollen or Bleeding Gums..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Mouth Breathing Habit | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Gum Treatments (<i>Periodontics</i>)..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Snoring | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Do you ever feel (or have you ever been told) that you don't have fresh breath? Yes No

Which foods cause you twinges of pain: hot cold sweet sour none

Do you avoid brushing any part of your mouth because of pain? Yes No . If yes, what part? _____

Cosmetic / Esthetic Evaluation

Are you delighted with your smile? Yes No Please *rate* your smile from 1 to 10 (*1 = I hate my smile, 10 = awesome*): _____

Would you like to have whiter teeth? Yes No Would you like to learn about your options to replace missing teeth? Yes No

If you had a *magic wand* what, if anything, would you change about your smile? _____

Please add anything you feel is important: _____

We respect your right to *choose* the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are *rarely* symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – *until* it is far too late. With your permission we would like to explain the *choices* available to achieve long-term health and beauty for your existing natural teeth.

Please check all that apply:

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and *last* for a long time.
- Spreading payments out over time may help me to achieve the excellent results I desire.
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
- I *am* interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
- Although I am not interested in a plan for long-term dental health, I *do* desire an office who will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

Name of person assisting patient with completing these forms: _____

Print name
Sign name
Date
Relationship to patient

Patient: _____

Print name
Sign name
Date

If patient is less than 18 years old, parent or legal guardian MUST sign above



Medical Health History

General Health (*please check*): Excellent Good Fair Poor

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 allergic to any medications? Yes No . Which medications: _____

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

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"/> |
| Heart Murmur or Arrhythmia..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Chemotherapy..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Mitral Valve Prolapse..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Drastic Weight Loss | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart Valve Replacement..... | 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"/> |
| Abnormal Blood Pressure..... | High <input type="checkbox"/> Low <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"/> | Prolonged Bleeding or Bruising..... | 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"/> | Latex Allergy..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Eye, Ear, Nose or Throat Disorder..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Epilepsy..... | 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"/> |
| Lymph Node Enlargement or Swollen Glands..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Anxiety or Mental Disorders | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Thyroid or Endocrine Disorder..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Eating Disorder..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Other Physical Problems or Symptoms: _____

Operations or Surgical Procedures: _____

Hospitalizations: _____

Notes: _____

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:

Dominique Diazgranados

Office: 305-255-772 Fax: 305-255-2152 E-mail: smile@pinecrestdental.com

Address: 12651 Pinecrest Parkway, 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: _____