SOUTH FLORIDA CENTER FOR PERIODONTICS & IMPLANT DENTISTRY

Patient Information Form

In order that we may better serve you, please complete in full

Today's date _____ Email _____

Name _____ Preferred name _____ Sex ❑ M ❑ F

Birthdate _____Height _____Weight _____ Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Address _____ City _____ State _____Zip _____

Home # ( ) - _____Work # ( ) - _____ Cell # ( ) - _____

Occupation _____Employer_____

Has anyone in your family ever been treated in our office? ❑ Yes ❑ No Name _____

Spouse's/partner's name _____Work # ( ) - _____ Cell # ( ) - _____

Emergency contact _____ Relationship _____ Contact # ( ) - _____

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

Are you completing this form for another person? ❑ Yes ❑ No

If so, your name_____ Relationship to patient_____

DENTAL HISTORY

Who is your dentist?_____ Phone # ( ) - _____

City_____ State _____Zip _____

Date of last cleaning _____Do your gums bleed when you brush or floss? ❑ Yes ❑ No

How frequently do you have dental cleanings? _____

Have you ever been treated for periodontal disease? (Deep cleanings, gum grafting, etc.) ❑ Yes ❑ No Year_____

If so, what type of treatment did you have? _____

Have you ever had a serious injury to your head or mouth? ❑ Yes ❑ No Year _____

If yes, please explain: _____

_____

Medical Information

Physician #1 _____ Specialty _____ Date of last visit _____
First Name Last Name

City _____ State _____ Phone ( ) - _____ Fax ( ) - _____

Physician #2 _____ Specialty _____ Date of last visit _____
First Name Last Name

City _____ State _____ Phone ( ) - _____ Fax ( ) - _____

Physician #3 _____ Specialty _____ Date of last visit _____
First Name Last Name

City _____ State _____ Phone ( ) - _____ Fax ( ) - _____

Have you been told that you need to **PREMEDICATE** or take antibiotics prior to a dental procedure? ❑ Yes ❑ No
Which antibiotic do you take? _____ For what condition? _____

Do you take or have you taken any of the medications listed below?

Fosomax® (alendronate)	❑ Yes	❑ No	Years _____	Zometa® (zoledronate)	❑ Yes	❑ No
Actonel® (risedronate)	❑ Yes	❑ No	Years _____	Humira® (adalimumad)	❑ Yes	❑ No
Boniva® (ibandronate)	❑ Yes	❑ No	Years _____	Embrel® (etanercept)	❑ Yes	❑ No
Reclast® (zoledronic acid)	❑ Yes	❑ No	Years _____	Remicade® (infliximab)	❑ Yes	❑ No
Aredia® (pamidronate)	❑ Yes	❑ No		Blood thinners (Plavix, Coumadin)	❑ Yes	❑ No
Prolia® (denosumab)	❑ Yes	❑ No		Other _____		

MEDICATIONS

List all medications you are currently taking, including over-the-counter drugs, such as vitamins and inhalers

Drug _____ Dose _____ Drug _____ Dose _____
Drug _____ Dose _____ Drug _____ Dose _____
Drug _____ Dose _____ Drug _____ Dose _____

ALLERGIES

To all **yes** responses specify type of reaction and use a separate sheet of paper if necessary

Local anesthetics _____	❑ Yes	❑ No	Codeine or other narcotics _____	❑ Yes	❑ No
Aspirin _____	❑ Yes	❑ No	Metals _____	❑ Yes	❑ No
Penicillin or other antibiotics _____	❑ Yes	❑ No	Latex (rubber) _____	❑ Yes	❑ No
Barbiturates, sedatives or sleeping pills _____	❑ Yes	❑ No	Iodine _____	❑ Yes	❑ No
Sulfa drugs _____	❑ Yes	❑ No	Other _____		

SURGERY

List ALL past surgery, major and minor

Year _____ Reason _____ Complications _____
Year _____ Reason _____ Complications _____
Year _____ Reason _____ Complications _____
Year _____ Reason _____ Complications _____

WOMEN ONLY: Is there a possibility that you are pregnant? ❑ Yes ❑ No Expected date of delivery? _____
Are you taking birth control pills or hormonal replacement? ❑ Yes ❑ No

Note: Antibiotics (such as Penicillin) may alter the efficacy of birth control pills. Consult with your physician for assistance regarding additional methods of birth control.

Medical Information

Please check appropriate box with your response indicating if you have or have not had any of the following:

Abnormal bleeding	❑ Yes	❑ No	Heart defect	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Heart murmur / leaky valve	❑ Yes	❑ No
Angina	❑ Yes	❑ No	Hepatitis (type) _____	❑ Yes	❑ No
Are you on blood thinners	❑ Yes	❑ No	Herpes	❑ Yes	❑ No
Arthritis / rheumatism	❑ Yes	❑ No	Hiatal hernia	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	High or low blood pressure	❑ Yes	❑ No
Atrial fibrillation	❑ Yes	❑ No	HIV / AIDS	❑ Yes	❑ No
Blood disease	❑ Yes	❑ No	Joint replacement (knee, hip, etc)	❑ Yes	❑ No
Cancer (type) _____	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Leukemia / lymphoma	❑ Yes	❑ No
Cigarette, pipe, or cigar smoking	❑ Yes	❑ No	Liver disease	❑ Yes	❑ No
How much? _____			Neck / back problems	❑ Yes	❑ No
Circulation problems	❑ Yes	❑ No	Pacemaker/defibrillator	❑ Yes	❑ No
Cortisone / steroids	❑ Yes	❑ No	Previous endocarditis	❑ Yes	❑ No
Cough, persistent or bloody	❑ Yes	❑ No	Psychiatric care	❑ Yes	❑ No
Dermal fillers _____	❑ Yes	❑ No	Radiation therapy	❑ Yes	❑ No
Diabetes (type) _____	❑ Yes	❑ No	Rheumatic or scarlet fever	❑ Yes	❑ No
Diarrhea, persistent	❑ Yes	❑ No	Shortness of breath	❑ Yes	❑ No
Digestive disorder	❑ Yes	❑ No	Sinus infection	❑ Yes	❑ No
Dizziness, fainting	❑ Yes	❑ No	Stroke (date) _____	❑ Yes	❑ No
Do you drink alcoholic beverages?	❑ Yes	❑ No	Sjorgren's syndrome	❑ Yes	❑ No
How often? _____			Stomach ulcer / hyperactivity	❑ Yes	❑ No
Do you use controlled substances?	❑ Yes	❑ No	Swelling of feet or ankles	❑ Yes	❑ No
Emphysema / bronchitis	❑ Yes	❑ No	Swollen glands – neck	❑ Yes	❑ No
Epilepsy / seizure	❑ Yes	❑ No	Thyroid disorder	❑ Yes	❑ No
Excessive urination	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Valve replacement	❑ Yes	❑ No
Headaches	❑ Yes	❑ No	Vision / hearing impaired	❑ Yes	❑ No
Heart attack (date) _____	❑ Yes	❑ No	Weight loss, unexplained	❑ Yes	❑ No

Do you have any disease, condition, or medical problem not listed above that you think I should know about?

Please explain: _____

_____

_____

I certify that I have read and understand the above. I have received a copy of the **South Florida Center for Periodontics & Implant Dentistry** Notice of Privacy Practices. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient Date

Responsible Party Information

Responsible party _____ Relationship to patient _____

Address _____ City _____ State_____ Zip _____

Home #(____) ____-_____ Cell #(____) ____-_____

_____

Signature of responsible party Date

DENTAL Insurance Information

Name of insured_____ Relationship to patient _____

Insured's birthdate_____ Social Security #____-____-_____Work #(____) ____-_____

Employer name _____

Employer address _____

Insurance company _____ Group #_____ ID #_____

Insurance company address _____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I have insurance coverage as stated above, and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Signature of Responsible Party Date