DAVIE FAMILY DENTAL
GENERAL & COSMETIC DENTISTRY

Welcome to Our Practice

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date:_____ Social Security # (SSN): _____ Birthdate:_____

Name:_____ _____ _____
FIRST LAST PREFER TO BE CALLED

Address:_____Home Phone: (____)_____

City: _____State: _____Zip: _____

Sex: ◯M ◯F ☐ Minor ◯Single ◯Married

Cell/Pager: (___) _____Email:_____

Employer: _____Business Phone: (____)_____

Occupation: _____Who should we thank for referring you?_____

Emergency Contact: _____Phone: (____)_____

DENTAL INSURANCE / PAYMENT INFORMATION

Person Responsible for Account:_____ Relationship to Patient: _____

Social Security # (SSN):_____ Birthdate: _____

Address:_____Home Phone: (____)_____

City: _____State: _____Zip: _____

Responsible Party Employer: _____Business Phone: (____)_____

Business Address: _____

Occupation: _____

Insurance Company:_____

Subscriber I.D. #: _____ Group#: _____ Secondary Insurance: ◯Y ◯N

DENTAL HISTORY

Former Dentist: _____ Date of Last X-Rays:_____

City, State:_____ How Often Do You Floss?_____

Date of Last Dental Visit: _____ How often Do You Brush? _____

Please complete:

Y	N		Y	N		Y	N	
◯	◯	BAD BREATH/TASTES	◯	◯	SENSITIVITY TO SWEETS	◯	◯	SENSITIVITY TO COLD
◯	◯	BLEEDING GUMS	◯	◯	ORTHODONTIC TREATMENT	◯	◯	JAW PAIN CLICKING/POPPING NOISES
◯	◯	BLISTERS ON UPS OR MOUTH	◯	◯	SENSITIVITY WHEN BITING	◯	◯	SENSITIVITY TO HEAT
◯	◯	FINGER NAIL BITING	◯	◯	ORAL SURGERY	◯	◯	NERVOUS ABOUT DENTAL TREATMENT
◯	◯	GRINDING TEETH	◯	◯	FREQUENT HEADACHES			
◯	◯	SMOKE / CHEW TOBACCO	◯	◯	PERIODONTAL TREATMENT			
◯	◯	LOOSE TEETH OR BROKEN FILLINGS	◯	◯	JAW, HEAD OR NECK INJURIES			

MEDICAL HISTORY

Patient Name: _____

Physician:_____ Date of last visit:_____

Please indicate if you have had any of the following:

Y	N	
○	○	AIDS
○	○	ANEMIA
○	○	ARTHRITIS, RHEUMATISM
○	○	ARTIFICIAL HEART VALVES
○	○	ARTIFICIAL JOINTS
○	○	ASTHMA
○	○	BACK PROBLEMS
○	○	BLEEDING ABNORMALLY (WITH EXTRACTIONS OR SURGERY)
○	○	BLOOD DISEASE/TRANSFUSION
○	○	CANCER
○	○	CHEMICAL DEPENDENCY
○	○	CHEMOTHERAPY
○	○	CHRONIC FATIGUE SYNDROME
○	○	CIRCULATORY PROBLEMS
○	○	CONGENITAL HEART DISEASE
○	○	CORTISONE TREATMENT
○	○	COUGH-PERSISTENT/BLOODY
○	○	DIABETES: TYPE _____
○	○	EMPHYSEMA
○	○	EPILEPSY
○	○	FAINTING OR DIZZINESS
○	○	GLAUCOMA
○	○	HEADACHES
○	○	HEART MURMUR
○	○	HEART PROBLEMS
○	○	HEPATITIS: TYPE _____
○	○	HEMOPHILIA
○	○	HERPES
○	○	HIGH BLOOD PRESSURE

BP _____

○	○	HIGH CHOLESTEROL
○	○	HIV POSITIVE
○	○	JAW PAIN
○	○	KIDNEY DISEASE
○	○	LIVER DISEASE
○	○	LOW BLOOD PRESSURE
○	○	MITRAL VALVE PROLAPSE
○	○	NEUROLOGICAL DISORDERS
○	○	OSTEOPOROSIS
○	○	PACEMAKER
○	○	PSYCHIATRIC CARE
○	○	RADIATION TREATMENT
○	○	RESPIRATORY DISEASE
○	○	RHEUMATIC FEVER
○	○	SCARLET FEVER
○	○	SEXUALLY TRANSMITTED DISEASE (STD)
○	○	SHORTNESS OF BREATH
○	○	SINUS TROUBLE
○	○	SPECIAL DIET
○	○	STROKE
○	○	SWELLING OF FEET, NECK OR ANKLES
○	○	THYROID PROBLEMS
○	○	TONSILLITIS
○	○	TUBERCULOSIS
○	○	TUMOR OR GROWTH ON HEAD OR NECK
○	○	ULCER
○	○	VERTIGO
○	○	DO YOU REQUIRE PRE-MED FOR DENTAL APPOINTMENTS

WOMEN ONLY

Y	N	
○	○	ARE YOU PREGNANT?
○	○	ARE YOU NURSING?
○	○	TAKING BIRTH CONTROL PILLS?

○	○	HAVE YOU BEEN UNDER ANY MEDICAL TREATMENT WITHIN THE LAST 2 YEARS?
○	○	ANY HOSPITAL STAYS?

LIST ANY MEDICAL CONDITION NOT LISTED:

MEDICATIONS

Please list **ALL** medications you currently take **including over the counter**:

ALLERGIES EVER HAVE AN ALLERGIC REACTION TO ANY OF THE FOLLOWING?

Y	N		Y	N	
○	○	ASPIRIN	○	○	LATEX
○	○	BARBITURATES (SLEEPING PILLS)	○	○	LOCAL ANESTHETIC
○	○	CODEINE	○	○	NAPROXEN(ALEVE)
○	○	IBUPROFEN (ADVIL)	○	○	PENICILLIN
○	○	IODINE	○	○	SULFA DRUGS

OTHER ALLERGIES: _____

ASSIGNMENT AND RELEASE

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims. I hereby authorize payment of insurance benefits directly to Craig A. Friedman, DMD PA.

I understand the information on this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully to the best of my knowledge. If further information is needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify this office of any changes in my health/medication. I understand responsibility for payment of dental services for myself and my dependants is mine and due at the time of service unless financial arrangements have been made. I agree to be responsible for payment of services not paid in whole or in part by my dental payor, which include all costs of collections and attorney fees, up through all levels of appeal.

Patient's Signature:_____ Date: _____