

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)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Years _____	Zometa® (zoledronate)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Actonel® (risedronate)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Years _____	Humira® (adalimumab)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Boniva® (ibandronate)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Years _____	Embrel® (etanercept)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reclast® (zoledronic acid)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Years _____	Remicade® (infliximab)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aredia® (pamidronate)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Blood thinners (Plavix, Coumadin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prolia® (denosumab)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Heart defect	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Anemia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Heart murmur / leaky valve	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Angina	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hepatitis (type) _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you on blood thinners	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Herpes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Arthritis / rheumatism	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hiatal hernia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Asthma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	High or low blood pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Atrial fibrillation	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	HIV / AIDS	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Blood disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Joint replacement (knee, hip, etc)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cancer (type) _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Kidney disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Chemotherapy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Leukemia / lymphoma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cigarette, pipe, or cigar smoking	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Liver disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
How much? _____					Neck / back problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Circulation problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Pacemaker/defibrillator	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cortisone / steroids	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Previous endocarditis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cough, persistent or bloody	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Psychiatric care	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Dermal fillers _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Radiation therapy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Diabetes (type) _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Rheumatic or scarlet fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Diarrhea, persistent	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Shortness of breath	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Digestive disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Sinus infection	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Dizziness, fainting	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Stroke (date) _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you drink alcoholic beverages?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Sjorgren's syndrome	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
How often? _____					Stomach ulcer / hyperacidity	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you use controlled substances?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Swelling of feet or ankles	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Emphysema / bronchitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Swollen glands – neck	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Epilepsy / seizure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Thyroid disorder	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Excessive urination	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tuberculosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Glaucoma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Valve replacement	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Headaches	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Vision / hearing impaired	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Heart attack (date) _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Weight loss, unexplained	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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