COOPER CITY FAMILY DENTISTRY

5900 HIATUS ROAD, #300 COOPER CITY, FL 33330

NAME _____ BIRTHDATE _____ SSN#_____

HOME PHONE _____ WORK or CELL PHONE _____

ADDRESS _____ CITY_____ STATE _____ ZIP_____

PATIENT'S OR GUARDIAN'S EMPLOYER _____ E-MAIL _____

PRIMARY PHYSICIAN _____ PHONE # _____

EMERGENCY CONTACT _____ PHONE # _____

MEDICAL HISTORY DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING?

ARTIFICIAL JOINTS	□ YES	□ NO	CANCER	□ YES	□ NO
RHEUMATOID ARTHRITIS	□ YES	□ NO	RADIATION THERAPY	□ YES	□ NO
OSTEOPOROSIS	□ YES	□ NO	CHEMOTHERAPY	□ YES	□ NO
RHEUMATIC FEVER	□ YES	□ NO	RESPIRATORY PROBLEMS	□ YES	□ NO
GLAUCOMA	□ YES	□ NO	ASTHMA	□ YES	□ NO
CORTISONE TREATMENTS	□ YES	□ NO	SHORTNESS OF BREATH	□ YES	□ NO
EPILEPSY/CONVULSION	□ YES	□ NO	TUBERCULOSIS	□ YES	□ NO
DIABETES	□ YES	□ NO	KIDNEY DISEASE	□ YES	□ NO
HIGH BLOOD PRESSURE	□ YES	□ NO	THYROID IMBALANCE	□ YES	□ NO
TOBACCO HABIT	□ YES	□ NO	STOMACH ULCERS	□ YES	□ NO
CIRCULATORY DISORDERS	□ YES	□ NO	LIVER DISEASE	□ YES	□ NO
STROKE	□ YES	□ NO	HEPATITIS	□ YES	□ NO
PROLONGED BLEEDING	□ YES	□ NO	BLOOD DISEASE	□ YES	□ NO
HEART PROBLEMS	□ YES	□ NO	AIDS/HIV+	□ YES	□ NO
MITRAL VALVE PROLAPSE	□ YES	□ NO	HERPES	□ YES	□ NO
ARTIFICIAL HEART VALVE	□ YES	□ NO	SYPHILIS	□ YES	□ NO
HEART ATTACK	□ YES	□ NO	PSYCHIATRIC CARE	□ YES	□ NO
ANGINA	□ YES	□ NO	ANXIETY	□ YES	□ NO
CARDIAC PACE MAKER	□ YES	□ NO			

** PLEASE NOTE ANY OTHER MEDICAL CONDITIONS NOT MENTIONED. (e.g. any illnesses or surgeries) _____

***(WOMEN)* 1. ARE YOU PREGNANT ? □ YES □ NO 2. ARE YOU BREAST-FEEDING? □ YES □ NO

LIST ANY MEDICATIONS THAT YOU ARE TAKING	LIST ANY ALLERGIES

DENTAL HISTORY DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING?

BLEEDING GUMS	□ YES	□ NO	LOOSE FILLINGS OR CROWNS	□ YES	□ NO
GINGIVITIS	□ YES	□ NO	JAW CLICKING OR POPPING	□ YES	□ NO
PERIODONTAL DISEASE	□ YES	□ NO	TMJ PROBLEMS	□ YES	□ NO
MOUTH SORES OR LUMPS	□ YES	□ NO	DENTAL OR TOOTH PAIN	□ YES	□ NO
ORAL CANCER	□ YES	□ NO	TOOTH SENSITIVITY	□ YES	□ NO
CLENCH OR GRIND TEETH	□ YES	□ NO	LATEX ALLERGY	□ YES	□ NO

** APPROXIMATELY WHEN WAS THE LAST TIME YOU VISITED A DENTIST? _____

** PLEASE LIST ANY OTHER DENTAL CONDITIONS THAT WE SHOULD BE AWARE OF. _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO PERFORM ANY FORM OF TREATMENT THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTHETICS AND / OR CERTAIN MEDICATIONS EMBODIES A CERTAIN RISK. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH CARE PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR DEPENDENTS.

_____ _____ _____

PATIENT OR GUARDIAN SIGNATURE DATE DR. SIGNATURE