

COOPER CITY FAMILY DENTISTRY

5900 HIATUS ROAD, #300 COOPER CITY, FL 33330

NAME _____ BIRTHDATE _____

CELL PHONE _____ E-MAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PRIMARY PHYSICIAN _____ PHONE # _____

EMERGENCY CONTACT _____ PHONE # _____

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

ARTIFICIAL JOINTS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	CANCER	<input type="checkbox"/> YES	<input type="checkbox"/> NO
RHEUMATOID ARTHRITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	RADIATION THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
OSTEOPOROSIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	CHEMOTHERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
GLAUCOMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	RESPIRATORY PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CORTISONE TREATMENTS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ASTHMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO
EPILEPSY/CONVULSION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TUBERCULOSIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DIABETES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	KIDNEY DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HIGH BLOOD PRESSURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	THYROID IMBALANCE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
TOBACCO HABIT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ACID REFLUX / GERD	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CIRCULATORY DISORDERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	LIVER DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
STROKE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HEPATITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PROLONGED BLEEDING	<input type="checkbox"/> YES	<input type="checkbox"/> NO	BLOOD DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HEART PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	AIDS/HIV+	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ARTIFICIAL HEART VALVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HERPES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HEART ATTACK	<input type="checkbox"/> YES	<input type="checkbox"/> NO	SYPHILIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ANGINA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PSYCHIATRIC CARE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CARDIAC PACE MAKER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ANXIETY	<input type="checkbox"/> YES	<input type="checkbox"/> 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	<input type="checkbox"/> YES	<input type="checkbox"/> NO	CLENCH OR GRIND TEETH	<input type="checkbox"/> YES	<input type="checkbox"/> NO
GINGIVITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	JAW CLICKING OR POPPING	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PERIODONTAL DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TMJ PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ORAL CANCER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	LATEX ALLERGY	<input type="checkbox"/> YES	<input type="checkbox"/> 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 _____