NORTH FLORIDA DENTISTRY
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Welcome

Patient Information

Date ______________________

Patient Name ______________________
Last Name

____
First Name　　Middle Initial

Address ______________________

City ______________________

State ____________ Zip ____________

Home (____) ______________________

Work (____) ______________ Ext ________

Cell Phone (____) ______________________

E-mail ______________________

Sex ☐ M ☐ F Age ____________

Birthdate ____________ Social Security # ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Occupation ______________________

Patient Employee/School ______________________

Employer/School Address ______________________

____

Employer/School Phone (____) ______________________

Spouse's Name ______________________

Spouse's Work (____) ______________________

Cell# (____) ______________________

Birthdate ____________ SS# ____________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

Dental Insurance

Who is responsible for this account? ______________________

Subscriber/Insured's Name ______________________

Birthdate ____________ Social Security # ____________

Relationship to Patient ______________________

Subscriber's Employer ______________________

Address of Employer ______________________

City/State/Zip ______________________

Name of Insurance Company ______________________

Address of Insurance Company ______________________

City/State/Zip ______________________

Telephone of Insurance Company ______________________

Group# ______________________

Member ID # ______________________

If you do not have all of the above information for insurance filing, payment is due in full on date of service. You will be given a receipt that can be used for filing the claim yourself with direct reimbursement to you.

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________ and assign directly to Dr. John Harrington/Dr. Olga Tron 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 authorize the use of my signature on all insurance submissions.

The above-names dentists may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Guardian or Personal Representative

____
Please print name of Patient, Guardian or Personal Representative

____
Date　　Relationship to Patient

What don't you like about your smile? ______________________

____

Dental History

Reason for today's visit ______________________

____

Former Dentist ______________________

Office Address ______________________

City/State/Zip ______________________

Telephone # of previous dentist ______________________

Date of last dental visit ______________________

Date of last dental X-rays ______________________

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or Cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth Breathing	☐ Yes	☐ No
Mouth pain when brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? ______________________

How often do you brush? ______________________

NORTH FLORIDA DENTISTRY

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following:

Question	Answer	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Premed required prior to any dental appointments?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Emergency Contacts and Phone number:	☐	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Problems	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Acid Reflux	◯ Yes ◯ No
		Back Problems	◯ Yes ◯ No	Bleeding abnormally with extractions	◯ Yes ◯ No		

Have you ever had any serious illness not listed? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature or Patient, Parent or Guardian:

X Date:__________