



**FLORIDA  
FAMILY  
DENTAL**

ORTHODONTIC AND IMPLANT CENTER

## ADULT REGISTRATION & MEDICAL HISTORY

Your complete oral health is our main concern. Communication is key to helping us give you a happy, healthy smile. We therefore ask that you complete this form in its entirety.

### 1 ABOUT YOU

Today's Date: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Name:** \_\_\_\_\_

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_ APT / CONDO #  
CITY STATE ZIP

Single  Married  Divorced  Widowed  Separated

Home #: (\_\_\_\_) \_\_\_\_\_ Pager/Cell #: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ DL #: \_\_\_\_\_

**Employer:** \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where and when are best times to reach you? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous/Present Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

### 2 SPOUSE INFORMATION

Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ DL #: \_\_\_\_\_

#### Person Responsible for Account:

Work #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relation: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

### 3 DENTAL INSURANCE

#### Primary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

#### Secondary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

#### In the event of an emergency, is there someone who lives near you that we should contact?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_

### 4 MEDICAL HISTORY

Do you have a personal physician?  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No

Please Explain: \_\_\_\_\_

**CONTINUED ON BACK**

# 4 MEDICAL HISTORY *continued*

Your current physical health is:  Good  Fair  Poor

Are you taking any prescription, over-the-counter, or supplement drugs?  
 Yes  No

Please list each one: \_\_\_\_\_

Do you smoke or use tobacco in any other form?  Yes  No

Have you ever taken Fosamax, Actonel, Boniva, or any other bisphosphonate?  Yes  No

Are you using a prescribed method of birth control?  Yes  No

Are you pregnant?  Yes  No Week #: \_\_\_\_\_

Are you nursing?  Yes  No

## Have you ever had any of the following diseases or medical problems? (Please circle option that applies)

- |                                       |                                  |
|---------------------------------------|----------------------------------|
| Y N Anemia/Radiation Treatment        | Y N Hemophilia/Abnormal Bleeding |
| Y N Artificial Bones/Joints/Valves    | Y N Hepatitis                    |
| Y N Arthritis                         | Y N High/Low Blood Pressure      |
| Y N Asthma                            | Y N HIV+/AIDS                    |
| Y N Blood Transfusion                 | Y N Hospitalized for Any Reason  |
| Y N Cancer/Chemotherapy               | Y N Kidney Problems              |
| Y N Congenital Heart Defect           | Y N Mitral Valve Prolapse        |
| Y N Diabetes                          | Y N Psychiatric Problems         |
| Y N Difficulty Breathing              | Y N Rheumatic/Scarlet Fever      |
| Y N Drug/Alcohol Abuse                | Y N Severe/Frequent Headaches    |
| Y N Emphysema/Glaucoma                | Y N Shingles                     |
| Y N Epilepsy/Seizures/Fainting Spells | Y N Sickle Cell Disease/Traits   |
| Y N Fever Blisters/Herpes             | Y N Sinus Problems               |
| Y N Heart Attack/Stroke               | Y N Tuberculosis (TB)            |
| Y N Heart Murmur                      | Y N Ulcers/Colitis               |
| Y N Heart Surgery/Pacemaker           | Y N Venereal Disease             |

Please list any serious medical condition(s) that you have ever had:

\_\_\_\_\_

\_\_\_\_\_

## Are you allergic to any of the following?

- |                        |                    |                  |
|------------------------|--------------------|------------------|
| Y N Aspirin            | Y N Erythromycin   | Y N Penicillin   |
| Y N Codeine            | Y N Jewelry/Metals | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Latex          | Y N Other        |

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

\_\_\_\_\_

# 5 DENTAL HISTORY

## Why have you come to the dentist today?

\_\_\_\_\_

Do you require antibiotics before dental treatment?  Yes  No

Are you currently in pain?  Yes  No

Have you ever had a serious/difficult problem associated with any previous dental work?  Yes  No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?  Yes  No

Your current dental health is:  Good  Fair  Poor

Do you like your smile?  Yes  No

Do your gums ever bleed?  Yes  No

Have you ever had periodontal disease?  Yes  No

How many times a week do you floss? \_\_\_\_\_ a day do you brush? \_\_\_\_\_

Type of bristles?  Hard  Medium  Soft

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that if credit is requested, a credit check may be required and I hereby grant Dr. \_\_\_\_\_ this authorization.

I hereby authorize payment directly to Florida Family Dental for the dental benefits otherwise payable to me.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

**Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.**

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

\_\_\_\_\_

### MEDICAL HISTORY UPDATE

1. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

2. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

3. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_