FORT LAUDERDALE
PERIODONTICS AND IMPLANT DENTISTRY

Patient Information

Name: _____ **Date:** _____

Mailing Address: _____

City, State, Zip: _____

Email: _____ **Sex:** ☐ **Male** ☐ **Female** **Age:** _____

Birthdate: _____

Home Phone #: _____ **Cell Phone #:** _____

Work Phone #: _____ **Best Number to Contact:** _____

May We Leave a Message at the Number Designated To Contact? ☐ **Yes** ☐ **No**

In Case of Emergency, contact: Name: _____

Relationship: _____ **Phone #:** _____

Current Employment Status:
☐ **Working full-time, Occupation:** _____

Employer Mailing Address: _____

City, State, Zip: _____

☐ **Working part-time** ☐ **Retired** ☐ **Not employed due to other responsibilities (student, raising children, etc.)**
☐ **Medical leave, disability** ☐ **Unemployed** ☐ **Other (please specify):** _____

Martial Status:
☐ **Married** ☐ **Separated** ☐ **Widowed** ☐ **Divorced** ☐ **Never Married** ☐ **Domestic Partnership**

How Did You Hear About Us?
☐ **Website/Internet** ☐ **Referring Doctor** ☐ **Another patient** ☐ **Other (please specify):** _____

Dental Insurance

Subscriber's Name: _____ **Relationship to Patient** _____

Insurance Company: _____ **Plan Name:** _____

Group Number: _____ **Birthdate:** _____ **SS#:** _____

Secondary Dental Insurance, If Applicable

Subscriber's Name: _____ **Relationship to Patient** _____

Insurance Company: _____ **Plan Name:** _____

Group Number: _____ **Birthdate:** _____ **SS#:** _____

Dental History

Reason for Today's Visit:_____

General Dentist: _____ **How often do you: brush** _____ **floss** _____**?**

Date of Last Dental Visit:_____ **Date of Last Dental Cleaning:**_____

Have you ever had periodontal (gum) treatments? ☐ Yes, _____ **(months/years) ago. ☐ No**

What are your main concerns regarding your oral health? _____

Do you have any of the following? (Check All That Apply).

☐ **Bad Breath**
☐ **Bleeding Gums**
☐ **Blisters on lips or mouth**
☐ **Broken fillings**
☐ **Clicking/popping jaw**
☐ **Dentures**
☐ **Difficulty chewing**
☐ **Dry mouth**
☐ **Food collection between teeth**
☐ **Grinding Teeth**
☐ **Swollen/tender gums**
☐ **Jaw pain**
☐ **Loose teeth**
☐ **Mouth pain**
☐ **Mouth breathing**
☐ **Pain around ear**
☐ **Sensitivity to cold**
☐ **Sensitivity to heat**
☐ **Sensitivity to sweets**
☐ **Sensitivity when biting**
☐ **Growth(s) in mouth**
☐ **Orthodontic Treatment**
☐**Past Complications from dental treatment. Please specify:**_____
_____
_____
_____

Medical History & Health Information

Primary Care Physician: _____ **Phone No.** _____

Last Date of Visit: _____ **Pharmacy:** _____ **Phone No:** _____

ALLERGIES: **Are you allergic to any of the following? (Check ALL that apply).**

☐ **Aspirin**
☐ **Adhesive Tape**
☐ **Barbiturates**
☐ **Codeine**
☐ **Erythromycin**
☐ **Jewelry**
☐ **Ibuprofen**
☐ **Latex**
☐ **Local Anesthetics**
☐ **Metals**
☐ **Penicillin**
☐ **Sulfa**
☐ **Tetracycline**
☐ **Other (please specify):**_____
_____
_____

CURRENT MEDICATIONS:

Are you currently taking blood thinners? ☐ No ☐ Yes, I am currently taking: _____

Do you require premedication before seeing a dentist? ☐ No ☐ Yes, I am required to take: _____

Have you ever taken bisphosphonate medications? ☐ No ☐ Yes, I am currently taking: _____

Please list any other medications you are taking: _____

_____

LIFESTYLE FACTORS:

Do you currently: Smoke, ☐ No ☐ Yes, _____ **packs/day. Use Chewing Tobacco, ☐ No ☐ Yes,** _____ **times/day.**

Use Recreational Drugs, ☐ No ☐ Yes, I use the following: _____

WOMEN ONLY:

Are you pregnant? □ No □ Yes **Are you breastfeeding? □ No □ Yes**

PAST MEDICAL HISTORY: **Have you experienced/been diagnosed with any of the following? (Check ALL that apply).**

□ Alcoholism
□ AIDS
□ Anemia
□ Arthritis, Rheumatism
□ Asthma
□ Back Problems
□ Cancer
□ Chemical Dependency
□ Chemotherapy
□ Circulatory Problems
□ Cortisone Treatments
□ Cough, persistent or bloody
□ Diabetes
□ Emphysema
□ Epilepsy
□ Fainting/dizziness
□ Glaucoma
□ Headaches
□ Heart Problems
□ Hepatitis Type _____
□ Herpes
□ High Blood Pressure
□ HIV Positive
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Low Blood Pressure
□ Nervous Pressure
□ Psychiatric Care
□ Radiation Treatment
□ Respiratory Disease
□ Scarlet Fever
□ Shortness of Breath
□ Sinus Trouble
□ Skin Rash
□ Special Diet/Weight Loss
□ Stroke
□ Swollen Feet/Ankles
□ Swollen Neck Glands
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Tuberculosis
□ Tumors/Growths
□ Ulcer
□ Venereal Disease
□ Artificial Health Valves
□ Artificial Joints/Screws/Pins
□ Bleeding abnormally
□ Blood Disease
□ Congenital Heart Lesions
□ Heart Murmur
□ Hernia Repair
□ Mitral Valve Prolapse
□ Pacemaker
□ Rheumatic Fever

Do you have any conditions not listed above or is there anything else you feel we should know about your medical history? □ No □ Yes, (If yes, explain) _____
_____

CONSENTS:

Medical History: To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever has a change in health.

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage as outlined above and assign Dr. Camacho or Dr. Rosenbaum directly all insurance benefits. 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.

Authorization to Release Protected Health Information: I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize Dr. Camacho and Dr. Rosenbaum to use and disclose my protected health information to carry out: 1) Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); 2) Obtaining payment from third party payers (e.g. my insurance company); 3) The day-to-day healthcare operations of your practice. This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying in writing Dr. Camacho or Dr. Rosenbaum. However, if I do revoke this authorization it will not have any effect on any of the actions taken by Dr. Camacho and Dr. Rosenbaum disclosing the PHI prior to the receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization

_____ Date:_____

Patient or Guardian Signature

FOR OFFICE USE ONLY:
Signature of Reviewing Provider: _____ Date: _____