OBROCHTA CENTER FOR DENTAL HEALTH

4464 CENTRAL AVENUE * St. Petersburg, FL 33711* (727) 321-4464

Please fill out both sides.

PATIENT INFORMATION: ***THANK YOU FOR CHOOSING OUR PRACTICE FOR YOUR DENTAL NEEDS. PLEASE COMPLETE THIS FORM IN INK. IF YOU HAVE ANY QUESTIONS, DO NOT HESITATE TO ASK FOR ASSISTANCE. WE WILL BE HAPPY TO HELP.***

NAME: (FIRST, MI, LAST)			**TODAY'S DATE:**
ADDRESS: (Street #,Unit #, City, State, Zip)		**HOME PHONE:**	**CELL PHONE:**
SOCIAL SECURITY #	**Do you text on your phone?**	**DATE OF BIRTH:**	**How would like us to contact you? _____phone _____text**
DRIVER LICENSE NUMBER / STATE:		**E-MAIL ADDRESS:**	

STUDENT? __YES __NO NAME OF SCHOOL:

ARE YOU: (CIRCLE ONE) MINOR SINGLE MARRIED SEPARATED DIVORCED WIDOWED

NAME OF YOUR EMPLOYER:	OCCUPATION:
BUSINESS ADDRESS/ CITY/ STATE/ ZIP	WORK PHONE #:
CONTACT IN CASE OF EMERGENCY:	CONTACT PHONE #:

WHOM MAY WE THANK FOR REFERRING YOU TO US?

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:	RELATIONSHIP TO PATIENT:
ADDRESS/ CITY/ STATE/ ZIP	HOME PHONE #:
NAME OF EMPLOYER:	WORK PHONE #:

PRIMARY DENTAL INSURANCE INFORMATION

NAME OF INSURED:		RELATIONSHIP TO PATIENT:
SOCIAL SECURITY #:	DATE OF BIRTH:	DATE EMPLOYED:
EMPLOYER NAME:		WORK PHONE #:
NAME OF INSURANCE COMPANY:		GROUP #:
INSURANCE ADDRESS: (CITY, STATE, ZIP)		PHONE #:

DO YOU HAVE SECONDARY DENTAL INSURANCE COVERAGE: ____YES ____NO

IF YES, PLEASE SUPPLY US WITH AN INSURANCE CARD TO DUPLICATE.

See other side

DENTAL HISTORY INFORMATION

FORMER DENTIST	ADDRESS/ CITY/ STATE/ ZIP/Phone #		
DATE OF LAST DENTAL EXAM:	DATE OF LAST X-RAYS:	HOW OFTEN DO YOU BRUSH?	HOW OFTEN DO YOU FLOSS?

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:
BAD BREATH / BLEEDING GUMS / CLICKING OR POPPING JAW / FOOD COLLECTION BETWEEN TEETH / GRINDING TEETH / LOOSE TEETH OR BROKEN FILLINGS / PERIODONTAL DISEASE/STAINED ENAMEL/CROOKED OR CROWDING OF TEETH / SENSITIVITY TO COLD / SENSITIVITY TO HOT OR SWEET / SENSITIVITY WHEN BITING DOWN / SORES OR GROWTHS IN YOUR MOUTH

MEDICAL HISTORY

PHYSICIAN:			DATE OF LAST VISIT:
HAVE YOU EVER TAKEN ANY OF THE FOLLOWING	**Skelid___ Fosamax___ Aredia___ Zometa___**	**BONIVA_____ Actonel_____**	ALLERGIES:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

HAVE YOU IN PAST OR PRESENT TAKEN ANY WEIGHT MANAGEMENT OR HERBAL SUPPLEMENTS?	ARE YOU PREGNANT?	NURSING?	TAKING BIRTH CONTROL PILLS?

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

__ AIDS	__ LYME DISEASE	__ HEPATITIS___A ___B ___C	__ RHEUMATIC FEVER
__ ANEMIA	__ COUGH, PERSISTENT	__ HIGH BLOOD PRESSURE	__ SCARLET FEVER
__ ARTHRITIS, RHEUMATISM	__ COUGH UP BLOOD	__ HIV POSITIVE	__ SHORTNESS OF BREATH
__ ARTIFICIAL HEART VALVES	__ DIABETES	__ JAW PAINS	__ SKIN RASH
__ ARTIFICIAL JOINTS/PINS/RODS/PLATES	__ EPILEPSY	__ KIDNEY DISEASE	__ STROKE
__ ASTHMA	__ FAINTING	__ LIVER DISEASE	__ SWOLLEN FEET/ANKLES
__ BACK PROBLEMS	__ GLAUCOMA	__ MITRAL VALVE PROLAPSE	__ THYROID PROBLEMS
__ BLOOD DISEASE	__ HEADACHES	__ NERVOUS PROBLEM	__ TOBACCO HABIT
__ CANCER* *PLEASE SPECIFY*_____	__ HEART MURMUR	__ PACEMAKER	__ TONSILLITIS
__ CHEMICAL DEPENDENCY	__ HEART PROBLEMS	__ PSYCHIATRIC CARE	__ TUBERCULOSIS
__ CHEMOTHERAPY	__ HIGH CHOLESTEROL	**__ RADIATION TREATMENT*** (PAST OR PENDING)	
__ CIRCULATORY PROBLEMS	__ HEMOPHILIA	__ RESPIRATORY DISEASE	__ ULCER
__ SEXUALLY TRANSMITTED DISEASE	__ OSTEOPEROSIS	__ CROHN'S DISEASE	__ HERPES

___ NONE OF THE ABOVE

HAS ANYONE EVER TOLD YOU THAT YOU STOP BREATHING OR SNORE DURING SLEEP? ___YES ___NO

HAVE YOU BEEN DIAGNOSED WITH A SLEEPING DISORDER? PLEASE EXPLAIN:

ARE YOU INTERESTED IN BOTOX OR DERMAL FILLERS? ___YES ___NO

AUTHORIZATION:

I CERTIFY THAT I HAVE READ AND UNDERSTAND THAT THE ABOVE INFORMATION IS TRUE 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 RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILDREN DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYOR AND/OR HEALTH PRACTITIONER. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

PATIENT'S SIGNATURE (OR PARENT IF A MINOR):	**DATE:**

IF YOU HAD A MAGIC WAND HOW WOULD YOU CHANGE YOUR SMILE?