Boyette

10825 Boyette Road Riverview, FL 33569 |

PERSONAL INFORMATION

1

Title: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr.
Date:_____/_____/_____

Last Name: _____ **First Name:** _____ **MI:** _____

Preferred Name (Nickname): _____ **Date of Birth:**____/_____/_____

SSN: _____ - _____ - _____ **Marital Status:** ( ) Married ( ) Single ( ) Other
Gender: ( ) Male ( ) Female

Home Address: _____ **Apt #:**_____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number (Preferred): _(_____)_____-_____ ( ) Cell ( ) Home ( ) Work ( ) Other

Phone Number (Alternate): _(_____)_____-_____ ( ) Cell ( ) Home ( ) Work ( ) Other

Employer: _____ **Occupation:** _____

May we call you at work? ( ) Yes ( ) No **Email Address:** _____

IN CASE OF EMERGENCY

Name: _____ **Phone:** _(_____)_____-_____

Relationship: _____

HOW WERE YOU REFERRED TO OUR OFFICE?

( ) Internet (Google, Bing, Yahoo, etc.)
( ) Dental Insurance Company
( ) Friend
( ) Facebook
( ) Saw Our Sign
( ) Other

Name:_____ Specify:_____

Reason for Today's Visit: ( ) Routine Check-Up/Get Established as a New Patient.
( ) It's been a while, but I'm not having any problems.
( ) I have a problem I'd like addressed.
Explain:

_____

DENTAL HISTORY

2

Name of Previous Dentist: _____ **Phone:** _(_____)_____-_____

City/State: _____ **Date of Last Dental Appointment:** _____

Date of Last Professional Cleaning: _____ **Date of Last Dental X-Rays:** _____

Do you have any crowns (caps)? ( ) Yes ( ) No
Does food catch between your teeth? ( ) Yes ( ) No
Are your teeth sensitive to the following?
Heat ( ) Yes ( ) No
Cold ( ) Yes ( ) No
Sweets ( ) Yes ( ) No
Biting/Chewing/Pressure ( ) Yes ( ) No

GUMS

Do you experience the following?
Bleeding gums when brushing ( ) Yes ( ) No
Swollen gums ( ) Yes ( ) No
Unpleasant taste/odor in mouth ( ) Yes ( ) No
Avoid part(s) of mouth while brushing ( ) Yes ( ) No
Bad breath ( ) Yes ( ) No

Have you ever been treated for (or told you have) periodontal disease? ( ) Yes ( ) No **If treated, when?**_____

Do you floss regularly? ( ) Yes ( ) No **If yes, how often?** _____

TMJ/TMD

Do you experience the following?

Pain, popping or locking in jaw joint ( ) Yes ( ) No
Pain when opening wide or yawning ( ) Yes ( ) No
Clenching or grinding teeth ( ) Yes ( ) No
Frequent headaches, migraines ( ) Yes ( ) No
Frequent neck/shoulder aches ( ) Yes ( ) No
Shifting/loose teeth or changes in bite ( ) Yes ( ) No

COSMETIC

Do you like your smile? ( ) Yes ( ) No
Would you like your teeth whiter? ( ) Yes ( ) No
Have you had orthodontics (braces)? ( ) Yes ( ) No When was it completed?

_____

Is there any old dental work you don't like? ( ) Yes ( ) No
Specify:_____

Is there anything you would like to change? ( ) Yes ( ) No Specify:

_____

REPLACEMENT TEETH

3

Do you have any of the following?

Missing teeth ( ) Yes ( ) No
Bridges (fixed) to replace teeth ( ) Yes ( ) No
Partials (removable) to replace teeth ( ) Yes ( ) No
Dentures ( ) Yes ( ) No
Dental Implants to replace teeth ( ) Yes ( ) No
Dental Implants to support dentures ( ) Yes ( ) No

COMFORT

Have you ever had a bad experience in a dental office that caused you anxiety, or does a particular noise or action make you nervous?

( ) Yes ( ) No
Specify:

_____

Have you had nitrous oxide (laughing gas)? ( ) Yes ( ) No
Have you had IV Sedation (conscious sleep)? ( ) Yes ( ) No
Have you had Oral Sedation (sedative)? ( ) Yes ( ) No
Are you interested in trying sedation? ( ) Yes ( ) No

PHYSICIAN'S INFORMATION

Office Name: _____ **Phone:** _(_____)_____-_____

Physician's Name: _____ **Last Visit:** _____/_____/_____

GENERAL MEDICAL and HEALTH

Are you currently under a physician's care? ( ) Yes ( ) No

Specify:

_____

Are you taking any medications? ( ) Yes ( ) No

Specify (include OTC drugs, vitamins, birth control, etc):

_____

_____

Do you have any health problems? ( ) Yes ( ) No

Specify:_____

__

Have you ever had surgery? ( ) Yes ( ) No

Specify:

_____

Are you allergic to any medications? ( ) Yes ( ) No

Medication: _____ Reaction:

_____

Have you ever had a reaction to local anesthetic? ( ) Yes ( ) No

Specify:

_____

Do you require premedication with antibiotics before appointments? ( ) Yes ( ) No

Specify:

_____

GENERAL MEDICAL and HEALTH (cont'd)

To the best of your knowledge, do you have (or have you ever been afflicted) with any of the following?

Rheumatic Fever/ Heart Murmur	( ) Yes	( ) No
Mitral Valve Problems	( ) Yes	( ) No

Artificial joints or valves	( ) Yes	( ) No
Seizures/Epilepsy/Stroke	( ) Yes	( ) No
Heart Ailment	( ) Yes	( ) No
High Blood Pressure	( ) Yes	( ) No
High Cholesterol	( ) Yes	( ) No
Respiratory Disease	( ) Yes	( ) No
Asthma/Hay Fever	( ) Yes	( ) No
Diabetes	( ) Yes	( ) No
Thyroid Disease	( ) Yes	( ) No
Liver/Kidney Problems	( ) Yes	( ) No
Prolonged Bleeding	( ) Yes	( ) No
Healing Complications	( ) Yes	( ) No
Take Blood Thinners or Aspirin	( ) Yes	( ) No
Hepatitis/HIV	( ) Yes	( ) No
Gastrointestinal Problems	( ) Yes	( ) No
Drug/Alcohol Abuse	( ) Yes	( ) No
Do you smoke/ chew tobacco?	( ) Yes	( ) No
Are you taking any diet drugs?	( ) Yes	( ) No
Are you pregnant?	( ) Yes	( ) No

PATIENT TREATMENT CONSENT

I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to present to me all of my options so that I may make an informed decision as to my course of treatment. Once treatment is agreed upon, I authorize the Dentist(s) to perform needed dental treatment and administer or prescribe any necessary medications.

I authorize my Dentist(s) to release treatment records, x-rays, or any other information deemed pertinent to my insurance carrier as necessary and/or requested to process my claims. I agree to be responsible for payment of all services rendered on my behalf or my dependents. All payments are due at the time of service.

_____ _____

Patient/Guardian Signature **Date**

_____

Dentist Signature