



# Affordable Dental Center of West Broward, P.A.

Medical Alert For Office Use

Thank you for visiting Affordable Dental Center of West Broward, P.A. We want your visit to be pleasant and comfortable. Please help by completing this form.

## Patient Information

Name \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL NICKNAME

Address \_\_\_\_\_  
STREET CITY STATE ZIP

Email Address \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_  
NAME & ADDRESS

- Married  Widowed  Single  Minor
- Separated  Divorce  Partnered for \_\_\_\_\_ years

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Spouse Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_ Employer \_\_\_\_\_  
NAME & ADDRESS

Work (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_

Emergency: Name \_\_\_\_\_ May we contact your work?  Yes  No

Relationship: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  Male  Female

## Insurance

Primary Dental Carrier (Who is responsible for this account?) \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_ Group # \_\_\_\_\_

Relation to patient \_\_\_\_\_

### Secondary Dental Carrier

Subscriber Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_ Group # \_\_\_\_\_

Relation to patient \_\_\_\_\_

### Insurance Authorization Statement (Sign & Date)

*I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions. The information on this page and the medical history is correct to the best of my knowledge.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

### If Patient is Under 18

Responsible Party \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address \_\_\_\_\_  
STREET

CITY STATE ZIP

Telephone \_\_\_\_\_

## Other Information

How did you hear about us? \_\_\_\_\_

What was the reason for today's visit? \_\_\_\_\_

Do you love your smile? \_\_\_\_\_

Is there anything you would like to change? \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

What did you like most about your last dentist? \_\_\_\_\_

## Medical History and Information

### Conditions

- |  |   |
|--|---|
| <input type="checkbox"/> Abnormal Bleeding       | <input type="checkbox"/> Heart Murmur                 |
| <input type="checkbox"/> Alcohol Abuse           | <input type="checkbox"/> Heart Surgery                |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Hemophilia                   |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Hepatitis A                  |
| <input type="checkbox"/> Angina Pectoris         | <input type="checkbox"/> Hepatitis B                  |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Hepatitis C                  |
| <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> High Blood Pressure          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Joint Replacement            |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Kidney Problems              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Liver Disease                |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Low Blood Pressure           |
| <input type="checkbox"/> Colitis                 | <input type="checkbox"/> Mitral Valve Prolapse        |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Pace Maker                   |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Psychiatric Problems         |
| <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Radiation Therapy            |
| <input type="checkbox"/> Drug Abuse              | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Seizures                     |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Facial Surgery          | <input type="checkbox"/> Shingles                     |
| <input type="checkbox"/> Fainting Spells         | <input type="checkbox"/> Sickle Cell Disease          |
| <input type="checkbox"/> Fever Blisters          | <input type="checkbox"/> Sinus Problems               |
| <input type="checkbox"/> Frequent Headaches      | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Thyroid Problems             |
| <input type="checkbox"/> HIV+ Aids               | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Ulcers                       |

### Allergies

- Aspirin  
 Codeine  
 Dental Anesthetics  
 Erythromycin  
 Latex  
 Metals  
 Penicillin  
 Sulfa  
 Tetracycline  
Other \_\_\_\_\_

- Y N**  
  Do you Smoke  
or use Tobacco?

- If Female**  
**Y N**  
  Are you taking Birth  
Control Pills?  
  Are you pregnant?  
If yes, # of weeks  
  Are you Nursing?

Please list any medications  
you are currently taking: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone # \_\_\_\_\_

## Treatment Authorization Form

*I authorized and give consent to perform dental services agreed between doctor and patient and/or parent of guardian to be necessary advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.*

Payment for all treatment and services rendered are my responsibility.

\_\_\_\_\_  
PATIENTS SIGNATURE

\_\_\_\_\_  
DATE

If patient is a child or requires a guardian:

\_\_\_\_\_  
PATIENTS SIGNATURE

\_\_\_\_\_  
DATE

# Dental History

When did you last visit the dentist? \_\_\_\_\_

What was the purpose of that visit? \_\_\_\_\_

How often do you floss? \_\_\_\_\_

How often do you brush? \_\_\_\_\_

**Please Circle**

Do you have (or can you obtain) a complete set of x-rays taken in the past 18 months? **Yes / No**

Do any of your teeth hurt? \_\_\_\_\_ **Yes / No**

**If yes**, please explain \_\_\_\_\_

Please circle if any of your teeth or gums are sensitive or tender:

when you eat?      to cold?      to hot?      to sweets?

Are there any growths or sores in your mouth? \_\_\_\_\_ **Yes / No**

Do you have any pain or clicking in your jaw joints? \_\_\_\_\_ **Yes / No**

Do you grind or clench your teeth? \_\_\_\_\_ **Yes / No**

Are any of your teeth moving or becoming loose? \_\_\_\_\_ **Yes / No**

Do you catch food in or around any of your teeth or gums? \_\_\_\_\_ **Yes / No**

Do your gums bleed while brushing your teeth? \_\_\_\_\_ **Yes / No**

Do you have bad breath? \_\_\_\_\_ **Yes / No**

Please **circle** if you have previously had any of the following dental treatments:

Orthodontic treatment (braces)      Periodontics treatment (gum and bone therapy)

Oral surgery (extraction or implants)      Endodontic treatment (root canal therapy)

Tooth Whitening      Porcelain Veneers      Bonding

While having previous dental treatment, have you ever (please **circle** if **Yes**):

Fainted?      Had an allergic reaction?      Had abnormal bleeding?      Other complications?

How do you feel about the appearance of your teeth? \_\_\_\_\_

If you could change your smile, how would you change it? \_\_\_\_\_

Do you have any other dental concerns? \_\_\_\_\_ **Yes / No**

**if yes**, please explain: \_\_\_\_\_

***I fully understand the questions asked on this form. I authorized the release of any information upon the written request of a third party payer or health care practitioner. To the best of my knowledge, all of the preceding answers are true and correct. If I have any changes in my oral health status, I will inform the doctor prior to or at my next appointment.***

\_\_\_\_\_ Date

\_\_\_\_\_ Patient's Name

\_\_\_\_\_ Patient's Signature