PATIENT INFORMATION

St. Johns Family DENTISTRY

Patient Name | Date of Birth | Age | Today's Date

❍ Miss ❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. I prefer to be called _____ ❍ Male ❍ Female

Home Address | City | State | Zip

❍ Single ❍ Married ❍Divorced ❍ Widowed ❍ Separated SS# ___-___-___ DL# _____

Home Phone | Cell | Work | Ext | Email

Employer | Address | Occupation | How long?

Where and when can we reach you? _____

Other family members seen by us? _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Primary Dental Insurance | Insurance Company Name | Group/Plan/Local/Policy#

Address | Phone

Insured's Name _____ **Relation** _____

Insured's date of birth? _____ **Insured's SS#** ___-___-_____ **Insured's Employer** _____

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

Name | Relation | Home Phone | Work / Cell

How did you hear about St. Johns Family Dentistry?

❍Yellow Pages ❍Mail / Coupon ❍Referral ❍Internet ❍TV ❍Billboard ❍Drive-By

❍Other _____

Whom may we thank for referring you? _____

2225 A 1 A SOUTH, SUITE 3A I ST. AUGUSTINE, FLORIDA 32080 I T 904.471.7300 F 904.471 .2708
www.StAugustineDentist.com

MEDICAL &
DENTAL HISTORY

St. Johns Family DENTISTRY

Patient Name _____ **Date of Birth:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions accurately and honestly.

I have come to the dentist today because:

Are you currently in pain?	○Y	○N		Are you currently under a physician's care?	○Y	○N	
Have you ever had a serious or difficult problem associated with any previous dental work?	○Y	○N		Have you been hospitalized or had a major operation?	○Y	○N	
Discomfort in your jaw joint (TMJ I TMD)?	○Y	○N		Have you ever had a serious head or neck injury?	○Y	○N	
Your assessment of your current health is:	*Good*	*Fair*	*Poor*	Are you on a special diet?	○Y	○N	
How many times a week do you floss?	_____			Do you use controlled substances?	○Y	○N	
How many times a day do you brush?	_____			Do you smoke or use tobacco?	○Y	○N	
Do your gums ever bleed?	○Y	○N		Do you take or have you taken medication for bone loss:			
Have you ever had periodontal (gum) treatment?	○Y	○N		Bisphosphonate Derivative (Fosomax, Boniva)	○Y	○N	
Type of tooth brush?	*Rotary*	*Hard*	*Medium* *Soft*	**Women:** *Are you pregnant?*	○Y	○N	
				Taking Oral Contraceptives?	○Y	○N	
				Nursing?	○Y	○N	

Please explain any "YES" answers: _____

List all current medications: _____

Previous / Present Dentist: _____ **Last visit date** _____

Previous / Present Physician: _____ **Last visit date** _____

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Anesthetics

Other allergies: _____

Do you have or have had any of the following? (Please circle all that apply)

AIDS/HIV	Chest Pains Lung	Genital Herpes	Leukemia	Sinus Trouble
Alzheimer's disease	Disease	Glaucoma	Liver Disease	Spina Bifida
Anaphylaxis	Cold Sores/Fever Blisters	Hay Fever	Low Blood Pressure	Stomach/Intestinal
Anemia Convulsions	Congenital Heart	Heart Attack/Failure	Mitral Value Prolapse	Disease
Angina	Disorder	Heart Murmur	Pain in Jaw Joints	Stroke
Arthritis/Gout	Cortisone Medicine	Heart Pace Maker	Parathyroid Disease	Swelling of Limbs
Artificial Heart Valve	Drug Addiction	Heart Trouble/Disease	Psychiatric Care	Thyroid Disease
Artificial Joint	Easily Winded	Hemophilia	Radiation Treatment	Tonsillitis
Asthma Hives or Rash	Emphysema	Hepatitis A	Recent Weight Loss	Tuberculosis
Blood Disease	Epilepsy or Seizures	Hepatitis B or C	Renal Dialysis	Tumors or Growths
Blood Transfusion	Excessive Bleeding	Herpes	Rheumatic Fever	Ulcers
Breathing Problems	Fainting I Dizziness	High Blood Pressure	Rheumatism	Venereal Disease
Bruise Easily	Frequent Cough	Hypoglycemia Diabetes	Scarlet Fever	Yellow Jaundice
Cancer	Frequent Diarrhea	Irregular Heartbeat	Shingles	
Chemotherapy	Frequent Headaches	Kidney Problems	Sickle Cell Disease	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Patient, Parent, or Guardian Signature **Date**