9th STREET DENTAL

GENERAL • COSMETIC • IMPLANTS • EMERGENCY

7451 Dr. M.L.K. Jr. St. N. ♦ St. Petersburg ♦ Florida ♦ 33702 ♦ (727) 219-1512

DATE: _____

Please fill out his form completely in ink (confidential.) If you have any questions please ask us – we will be happy to help.

Patient Information:

SSN: _____

Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____ Email_____

Circle What Applies: Child / Single / Married / Divorced / Separated / Widowed

If Student, Name of School_____ Circle One: Full Time / Part Time

Patient or Parent/Guardian's Employer_____ Work Phone_____

Spouse/Parent/Guardian's Name_____ Phone _____

Whom May We Thank you Referring You?_____

Person to Contact in Case of Emergency_____ Phone_____

Responsible Party:

Name of Person Responsible for Account_____ Relationship to Patient_____

Driver's License Number_____ Date of Birth_____

Email_____ Phone_____ Current Patient: Y / N (circle one)

Employer_____ Work Phone_____ SSN_____

Insurance Information:

Name of Insured_____ Relationship to Patient_____

Subscriber ID#/SSN_____ Date of Birth_____

Insurance Company_____ Group #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Patient Medical History

Physician_____Phone_____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	❒	❒
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	❒	❒
3. Are you taking any medication(s) including non-prescription medicine? If yes, please List _____ If you have a list of medications, please provide the front office staff with a copy.	❒	❒
4. Have you ever Taken Fen-Phen/Redux?	❒	❒
5. Do you use tobacco or any related tobacco products?	❒	❒
6. Do you use controlled substances?	❒	❒
7. Are you wearing contact lenses?	❒	❒
8. Do you have a persistent cough or throat clearing not associated with a known illness (last more than 3 weeks?)	❒	❒
9. ***Women Only:***		
a) Are you pregnant or think you may be pregnant?	❒	❒
b) Are you nursing?	❒	❒
c) Are you taking oral contraceptives?	❒	❒

10. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocaine)	❒ Yes / ❒ No
Penicillin or any other Antibiotics	❒ Yes / ❒ No
Sulfa Drugs	❒ Yes / ❒ No
Barbiturates	❒ Yes / ❒ No
Sedatives	❒ Yes / ❒ No
Iodine	❒ Yes / ❒ No
Aspirin	❒ Yes / ❒ No
Metals (e.g. nickel, mercury, etc.)	❒ Yes / ❒ No
Latex Rubber	❒ Yes / ❒ No

Other (please list) _____

11. Do you have or have you ever had any of the following?

High Blood Pressure	❒ Yes / ❒ No	Arthritis	❒ Yes / ❒ No
Heart Attack	❒ Yes / ❒ No	Joint Replacement/Implants	❒ Yes / ❒ No
Rheumatic Fever	❒ Yes / ❒ No	COPD	❒ Yes / ❒ No
Swollen Limbs	❒ Yes / ❒ No	Cancer	❒ Yes / ❒ No
Fainting/Seizures	❒ Yes / ❒ No	Radiation Treatment	❒ Yes / ❒ No
Asthma	❒ Yes / ❒ No	Chemotherapy	❒ Yes / ❒ No
Low Blood Pressure	❒ Yes / ❒ No	Tumor or Growths	❒ Yes / ❒ No
Epilepsy/Convulsions	❒ Yes / ❒ No	Sickle Cell Disease	❒ Yes / ❒ No
Leukemia	❒ Yes / ❒ No	Multiple Sclerosis	❒ Yes / ❒ No
Diabetes	❒ Yes / ❒ No	Hay Fever/Allergies	❒ Yes / ❒ No
Kidney Disease	❒ Yes / ❒ No	Mental Illness	❒ Yes / ❒ No
Liver Disease	❒ Yes / ❒ No	Stomach Troubles/Ulcers	❒ Yes / ❒ No
AIDS/HIV Infection	❒ Yes / ❒ No	Chest Pains	❒ Yes / ❒ No
Hepatitis	❒ Yes / ❒ No	Easily Winded	❒ Yes / ❒ No
Herpes	❒ Yes / ❒ No	Stroke	❒ Yes / ❒ No
Sexually Transmitted Disease	❒ Yes / ❒ No	Tuberculosis	❒ Yes / ❒ No
Thyroid Problem	❒ Yes / ❒ No	Glaucoma	❒ Yes / ❒ No
Heart Disease	❒ Yes / ❒ No	Weight Gain or Loss	❒ Yes / ❒ No
Cardiac Pacemaker	❒ Yes / ❒ No	Heart Trouble	❒ Yes / ❒ No
Heart Murmur	❒ Yes / ❒ No	Mitral Valve Prolapse	❒ Yes / ❒ No
Angina	❒ Yes / ❒ No	Jaundice	❒ Yes / ❒ No
Frequently Tired	❒ Yes / ❒ No	Bell's Palsy	❒ Yes / ❒ No
Anemia	❒ Yes / ❒ No	Bleeding Problems	❒ Yes / ❒ No
Emphysema	❒ Yes / ❒ No	Sinus Problems	❒ Yes / ❒ No
Respiratory Problems	❒ Yes / ❒ No	Headaches	❒ Yes / ❒ No

Other (please list) _____

Patient Dental History:

Name of Previous Dentist and Location_____

Date of Last Dental Exam_____ Date of Last Dental Cleaning_____

Do you wear Dentures or partials? ❒ Yes / ❒ No If yes, how old are they_____

Do any of the following Dental concerns apply to you?

Bad Breath	❒ Yes / ❒ No	Missing Teeth	❒ Yes / ❒ No
Bleeding Gums	❒ Yes / ❒ No	Sensitivity to pressure	❒ Yes / ❒ No
Blisters on Lips or in Mouth	❒ Yes / ❒ No	Sensitivity to hot or cold	❒ Yes / ❒ No
Burning Sensation on Tongue	❒ Yes / ❒ No	Stained/Dark teeth	❒ Yes / ❒ No
Clicking/Popping/Swollen/Tender Jaw	❒ Yes / ❒ No	Spaces/Gaps between teeth	❒ Yes / ❒ No
Clenching/Grinding of your teeth	❒ Yes / ❒ No	Tooth pain or aches	❒ Yes / ❒ No
Dry Mouth	❒ Yes / ❒ No	Head/Neck/Jaw injuries	❒ Yes / ❒ No
Food collection/packing between teeth	❒ Yes / ❒ No	Difficult extractions in the past	❒ Yes / ❒ No
Lip or Cheek biting	❒ Yes / ❒ No	Prolonged bleeding from extractions	❒ Yes / ❒ No
Loose or Broken Teeth	❒ Yes / ❒ No	Do you like your smile	❒ Yes / ❒ No
Loose or Broken fillings/crowns	❒ Yes / ❒ No		

Authorization and Release:

I certify that I have read and understand the above information 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 child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)

Date: _____

X _____

Doctor's Signature

Date: _____