PINES - PALM DENTAL CARE

DR. FERNANDO GUTIERREZ

Welcome to our office. We do our best to make appointments as convenient as possible. If at any time you have questions regarding your treatment, appointment, or fees, please feel free to ask. This "acquaintance form" will help us serve you better.

Please Print **Today's Date** ______________________

Mr./Mrs./Ms./Dr.____
Last Name *First Name* *Middle Initial*

minor *single* *married* *widowed* *divorced* *separated*

If child, parent's full name ____

Residence Address ____

City __________________________________ State _________ Zip ____________Date of Birth ___________________

Home Phone ____________________ Cell Phone ____________________ Email __________________________

S.S. # _________________________Occupation _______________________ Employer _________________________

Address ____ Work Phone _________________ Ext. ______

In case of an emergency, who should we contact? _____________________________ Phone# ______________________

Do you have dental Insurance? ______ If yes, what is the name of the insurance company ___________________________

Subscribers Name: ________________________________ SS#______________________ Group# _________________

Date of Birth _________________ Subscriber Id # ________________________Insurance phone # __________________

Please tell us whom we may thank for referring you to our office? ____

Has any member of your family ever been treated in our office? ____ If yes, whom? ________________________________
How did you hear about us? Ad _____Phone Book _____Web Site_____ other ________________________________

DENTAL HISTORY

What is the purpose of your visit today? ____

Has fear or discomfort kept you from regular visit? ____

Describe ____

Date of last Dental Appointment ____________________________Date of last X-rays _____________________________

Do you prefer nitrous oxide sedation (laughing gas) during treatment? ____

How would you describe your present dental health? Good Fair Poor

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Please circle if you have had problems with any of the following:

Bad breath	Grinding teeth	Sensitivity to heat
Bleeding gums	Loose teeth or broken fillings	Sensitivity to sweets
Clicking or popping jaw	Periodontal treatment	Sensitivity when biting
Food collection between teeth	Sensitivity to cold	Sores or growths in mouth

Do you smoke? _______ Do you wear dentures? _______ Do you like your smile? ________

MEDICAL HISTORY

Patient's Name ____ Date ________________________

Physician's Name ____ Date of last visit ________________________________

Office Number ____________________________ Fax Number________________________

Have you had any serious illness or operations? ______if yes, Describe ____

____

Please check all that apply:

Heart Disease ____	Chest pain ____	Congenital Heart Disease ____
Heart Murmur ____	High blood Pressure _____	Mitral Valve Prolapse____
Artificial Heart Valve ____	Heart Stint/Shunt _____	Heart Pacemaker _____
Rheumatic Fever _____	Arthritis/Rheumatism _____	Stroke _____
Artificial Joints _____	Kidney Trouble _____	Diabetes _____
Thyroid Problems _____	Osteoporosis _____	Emphysema _____
Chronic Cough _____	Cancer _____	Tuberculosis _____
Asthma _____	Hay Fever _____	Sinus Trouble _____
Allergies or Hives _____	Latex sensitivity _____	Radiation Therapy _____
Chemotherapy _____	Tumors _____	Hepatitis A _____
Hepatitis B _____	Hepatitis C _____	Liver Disease _____
Headaches _____	Venereal Disease _____	H.I.V. Positive _____
A.I.D.S. _____	Blood Transfusion _____	Hemophilia _____
Sickle Cell Disease _____	Neurological Disorders _____	Epilepsy or Seizures_____
Fainting or Dizzy Spells _____	Nervous/Anxious _____	Psychiatric Care _____
Cold Sores _____	Fever blisters _____	TMJ Disorder _____
Swelling of feet/ankles _____	Tonsillitis _____	Ulcer _____
Jaundice _____	Alzheimer _____	Low blood pressure _____

Do you take any anticoagulants (blood thinners)? _____, Name of medication ____

Do you Pre Medicate with antibiotics before any dental procedure? ____

Are you currently taking any medications? , If yes, please list:

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Please check all that apply. Have you had any allergic reaction to the followings?

Local Dental Anesthesia ________, if yes explain ____

Penicillin _____ sulfa drugs _____ barbiturates (sleeping pills) _____
Sedatives _____ Iodine _____ Aspirin _____
other __________________________

WOMEN ONLY: are you pregnant ______ if yes, ____ months Nursing? _______ Taking Birth Control Pills _______

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication. I hereby authorize doctor or designated staff to take x-rays, study models, photography, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication necessary.

Patient Name ____ Date __________________

Patient or Responsible Party Signature: ____

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