Gutierrez Dentistry
373 Sebastian Blvd. Sebastian, Florida 32958
772-589-7409

First Name: _____ MI: _____ Last Name:_____

Nickname: _____

Date of birth: _____ Sex: __Male __Female__

Family Status: __Single __Married __Child __Other

Social security number: _____ Email: _____

HOME ADDRESS: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred phone number:___Home___Cell___Work **Best Time to call**_____

Whom should we contact in an emergency? *(Please give phone # and relationship to you)*

_____

Whom are we allowed to speak to about your dental health? *(Besides you, parent, guardian, insurance)*

_____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION (if not patient)

Name of person responsible for the account: _____Phone: _____

DENTAL INSURANCE

Policy holder's name: _____

Patient relationship to insured: Phone: _____ Date of birth: _____

SSN: _____ Employer: _____

Insurance company name: _____ Phone number: _____

Address: _____

Insurance plan name: _____Insurance ID number: _____

Group ID number: _____ Union or local name: _____

Type of plan:_____

IF YOU HAVE SECONDARY INSURANCE, PLEASE INFORM THE FRONT DESK

MEDICAL HISTORY

Physician's Name: _____ *Phone number:* _____

Other physicians: _____

Please list any conditions of illnesses for which you are currently being treated: _____

PLEASE CHECK EACH BOX FOR ANY HEALTH CONDITIONS YOU HAVE

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By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

ADHD		Ear problems *(chronic)*		Heart-transplant and then valve problems	
Anemia		Eating or feeding disorder		Heart-valve problems(Mitral valve prolapse)	
Asthma		Genetic disorder		Heart-surgically corrected heart (ex. STENT, bypass)	
Auto-immune disease		Heart-chest pain/angina		Heart-uncertain of type	
Arthritis *(osteo, rheumatoid, lupus, fibromyalgia)*		Heart-birth defect		Heart-weak heart(cardiomyopathy)	
Autism spectrum disorder		Heart-clogged arteries		Hepatitis/liver problems	
Adrenal gland disorder		Heart-congestive heart failure		HIV/AIDS	
Bleeding disorder		Heart-defibrillator implanted		Hormone problem(ex. menstrual, sex, puberty)	
Blood pressure problems		Heart-enlarged heart(cardiomegaly)		Joint replacement with a prosthesis	
Brain/nerve disorder *(ex. MR, Alzh, Autism, MS,CP)*		Heart-endocarditis(infection)		Kidney/bladder disorder	
Cancer		Heart-heart attack		Lung(ex. emphysema, cystic fibrosis, transplant)	
Cold sores, oral herpes or shingles		Heart-heart murmur		Osteoporosis	
Diabetes		Heart-irregular heart beat (arrhythmia)		Psychiatric/behavioral problems	
Disability *(from birth or acquired since birth)*		Heart-peacemaker implanted		Sexually transmitted disease	
Seizure disorder(epilepsy)		Sinus problems(chronic)		Sleep apnea	
Stomach/gastrointestinal disorder		Stroke/TIA		Transplant-organ or stem cell	
Tuberculosis		Thyroid gland disorder		Vision problems(ex blindness, Glaucoma)	

Have you had a STROKE, HEART ATTACK, ARTIFICIAL JOINT REPLACEMENT in the last 6 months? ___Yes ___No

If there are any other medical conditions we should be aware of, please describe*:*_____

_____

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Allergy history:

☐ Dental restorative materials	☐ Food allergies	☐ Medication Allergy
☐ Latex allergy	☐ Seasonal of environmental	

Please select medications you are allergic to: __Penicillin __Iodine Dye __Codeine __Latex __Sulfa __ Aspirin

Please list any other allergies: _____

Do you use tobacco products? ____None ____Cigarette ____Cigar ____Smokeless ____Pipe

Preferred pharmacy name and telephone number: _____

List any Medications/vitamins you take currently:

_____

_____

_____

Have you taken BISPHOSPHONATES for osteoporosis or as chemotherapy for another disease?

DENTAL HISTORY

Why do you seek dental care now?

_____

Do you have any significant dental issues that you would like us to be aware of?

_____

_____

Have you had dental treatment recommended to you that you haven't completed? Yes No

If so, why not?_____

_____**I**

If you could change anything about your teeth, what would it be?_____

_____

When did you last have dental treatment?_____ **What was done?**_____

Name of dentist _____ **City**_____ **May we request records? Yes No**

What dental services have you had? (circle all that apply)

Cleanings Fillings Extractions Root Canals Caps or Crowns

Gum Treatment Orthodontics Implants TMJ Treatment

Bite Adjustment Other_____

Did you have any problems or undesirable experiences with previous dental treatments? _____

_____

Does dental care make you nervous? No Slightly Moderately Very

What can we do to help you be comfortable? _____

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_____

Is there anything else you want us to be aware of? _____

_____

I affirm that the information provided in these forms will be true and correct to the best of my knowledge. I certify that I understand the importance of a truthful health history and that my dentist and his/her staff will rely on the information provided for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may make in the completion of these forms.

Signature _____ Date _____

If not the patient, please give relationship: _____