*IF YOU HAVE DENTAL INSURANCE PLEASE PROVIDE THE FRONT DESK WITH A COPY OF YOUR CURRENT CARD, OR YOUR DENTAL INSURANCE INFORMATION, SO THAT WE MAY FILE CLAIMS ON YOUR BEHALF. YOUR INSURANCE COMPANY WILL REIMBURSE YOU. *

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

Patient Name: _____ - _____ - _____ - _____
First MI Last Preferred name

Date of birth: _____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Social security number: _____ Email: _____

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

Address: _____

_____
City State Zip code

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? _____

DENTAL HISTORY

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? If so, what & why?

_____

_____

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

_____

What dental services have you had? (Check 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? _____

_____

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Please provide previous Dental office information (Name, number and treatment performed)

_____

_____

What can we do to help you be comfortable? _____

_____

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

_____

MEDICAL HISTORY

Physician's Name: _____ Phone number: _____

Have you had a **STROKE**, **HEART ATTACK** or **ARTIFICIAL JOINTS** placed in the last **SIX MONTHS?** ☐ Yes ☐ No

Have you ever been asked to **PREMEDICATE** for a dental appointment? ☐Yes ☐No

Preferred pharmacy and phone number: _____

Please list any medications you are currently taking: _____

_____

_____

_____

Allergy history check all that apply:

☐ Aspirin	☐ Codeine	☐ Penicillin	☐ Erythromycin
☐ Tetracycline	☐ Local anesthetics (Novocain)	☐ Sulfa	☐ Iodine Dye
☐ Latex	☐ Dental restorative materials	☐ Food	☐ Seasonal
☐ Other			

If other please list: _____

Do you use tobacco products? ☐Yes ☐No

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Gutierrez
DENTISTRY

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Please check any of the following that you have had or presently have. By checking the box, it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ ADHD
- ☐ Adrenal Gland Disorder
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Auto Immune Disease
- ☐ Bleeding Disorder
- ☐ Blood pressure problems
- ☐ Brain/ nerve disorder
- ☐ Cancer
- ☐ Chronic Eating/feeding disorder
- ☐ Cold Sores/oral herpes/shingles
- ☐ Diabetes
- ☐ Disability from birth
- ☐ Ear problems
- ☐ Epilepsy/seizures
- ☐ Genetic disorder
- ☐ Heart attack
- ☐ Heart birth defect
- ☐ Heart chest/pain/Angina
- ☐ Heart clogged arteries
- ☐ Heart congestive failure
- ☐ Heart defibrillator implanted
- ☐ Heart enlarged (cardiomegaly)
- ☐ Heart infection (Endocarditis)
- ☐ Heart irregular beat
- ☐ Heart Murmur
- ☐ Heart Pacemaker Implanted
- ☐ Heart surg. corrected with stents/bypass
- ☐ Heart transplant, then valve problems
- ☐ Heart valve problems MVP
- ☐ Heart weak (cardiomyopathy)
- ☐ Hep A
- ☐ Hep B
- ☐ Hep C
- ☐ HIV/Aids
- ☐ Hormone problems
- ☐ Joint Replacements
- ☐ Kidney/bladder
- ☐ Lung problems
- ☐ Osteoporosis
- ☐ Psychiatric/behavioral
- ☐ Sinus problems (chronic)
- ☐ Sleep Apnea
- ☐ STD
- ☐ Stomach GI disorder
- ☐ Stroke/TIA
- ☐ Thyroid gland disorder
- ☐ Transplant- Organ/stem cell
- ☐ Tuberculosis
- ☐ Vision Problem

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

_____

_____

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: _____