Fort Myers Dental Care

Date ____________________

Name ____________________ Home Phone (Local) (   )____________

Address (Local) ____________________ Business Phone (   )____________

City ____________ State ____ Zip________ Cell Phone (   )____________

Address (Up North)____________________ Home Phone (Up North) (   )____________

City ____________ State ____ Zip________

Occupation ________ Employer ________ Social Security No.____________

Date of Birth ___/___/___ Sex M F Height________ Weight ______ Single ______ Married ______

Name of Spouse ________ Closest Relative________ Phone (   )____________

If you are completing this form for another person, what is your relationship to that person?____________

Referred by____________________

Dental Insurance Co., if covered ____________ Policy Holder's Name ____________

City____________________ State ________ Zip ________

Certificate Group, or Plan # ____________ Policy Holder's Soc. Sec. # ____________

Name of Employer____________ Policy Holder's Date of Birth ____________

Employer Address____________________ Employer Phone (   )____________

MEDICAL HISTORY

Physician's Name (In FL)____________________ Date of last physical exam ____________

Physician's Name (Up North)____________________

Do you have or have you had any of the following? Please indicate with check mark (✓).

____ Any heart problems
____ Mitral valve prolapse
____ High blood pressure
____ Low blood pressure
____ Circulatory problems
____ Nervous problems
____ Radiation treatments
____ Excessive bleeding
____ AIDS
____ Allergies to anesthetics

____ Allergies to medicines or drugs
____ Allergies to ____________
____ Anemia
____ Arthritis
____ Asthma
____ Diabetes
____ Hepatitis
____ Herpes
____ Malignancies
____ Psychiatric care

____ Rheumatic Fever
____ Scarlet Fever
____ Sinus Problems
____ Stroke
____ Total Joint Replacement
____ Tonsilitis
____ Tuberculosis
____ Ulcer
____ Venereal Disease
____ Other

Have you ever been told you need pre-med for dental treatment? yes/no Why? ____________

If yes, what antibiotic do you take? ____________________

Are you pregnant?__________ Blood Pressure: S________/ D________/ P________

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. List any medications you are taking.

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Consent for Treatment

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs, and to perform any and all forms of treatment to include medication and therapy. I understand the use of anesthetics embodies a certain risk. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I hereby certify that I have read and fully understand the consent for treatment.

Signature of patient, parent or guardian:____________________Date:____________