MEDICAL & DENTAL HISTORY FORM

Last Name	First Name:	Initial:	Sex:

Address:	Today's Date:

City State Zip Code:	Email:

Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.	Marital Status:

Dental Insurance Company:	Member Id:	800 Number:

List family members who come to our office (Name)	Home Phone:	Work Phone:	Cell Phone:

Pharmacy:	Pharmacy Address:	Pharmacy Phone:

In case of emergency who should be notified:	Relationship:	Phone:

Whom may we thank for referring you?	Relationship:

Current age:__________ Reason for today's visit:______________________________

Date of last dental care and former dentist: ______________________________

Check (✓) if you have had problems with any of the following:

❒ Bad Breath
❒ Loose teeth or broken fillings
❒ Sensitivity when biting
❒ Grinding Teeth
❒ Sensitivity to sweets
❒ Food collection between teeth
❒ Sensitivity to hot
❒ Clicking or popping jaw
❒ Sensitivity to cold
❒ Bleeding gums
❒ Periodontal treatment
❒ Sores or growths in your mouth

How often do you floss? ____________ How often do you brush? ______________________

Smoking habits: [ ] Yes [ ] No Packs per day: ______________________

Would you be interested in:
- * Straighter teeth with clear aligner therapy? [ ] Yes [ ] No
- * Whiter teeth? [ ] Yes [ ] No
- * Reducing snoring? [ ] Yes [ ] No

Stress level: Low [ ] Medium [ ] High [ ]

Although in Dentistry we primarily treat the mouth and all of its structures, the oral cavity is connected to the rest of the body and acts as the Gateway to many of its organ systems. Health problems that you may have or medications that you may be taking could have an important interrelationship with the Dentistry you will receive. therefore, it is important that you answer all of the pertinent questions. Thank you.

Physician Name:	Physician Address:	Physician Phone:

Medications: Please list all prescription and non-prescription medications, vitamins, home remedies, and herbs. (If you have a list we can take a copy of it)

Medication/ Supplements	**Dose (mg per pill, doses per day)**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Allergies or reactions to medicines or other materials/products:

Aspirin	Yes [ ]	No [ ]	Erythromycir	Yes [ ]	No [ ]	Jewelry	Yes [ ]	No [ ]
Codein	Yes [ ]	No [ ]	Penicillin	Yes [ ]	No [ ]	Latex	Yes [ ]	No [ ]
Gluten	Yes [ ]	No [ ]	Tetracycline	Yes [ ]	No [ ]	Metals	Yes [ ]	No [ ]
Nuts	Yes [ ]	No [ ]	Clindamycin	Yes [ ]	No [ ]	Sulfa	Yes [ ]	No [ ]
Anesthetic	Yes [ ]	No [ ]	Which: ______________________					
Fruits	Yes [ ]	No [ ]	Which: ______________________					
Others:	Yes [ ]	No [ ]	Which: ______________________					

Personal medical history

Are you required to pre-medicate before any dental treatment: Yes [ ] No [ ]

Are you taking any of the following:

[ ] Aspirin	[ ] Antidepressants or tranquilizers	[ ] Osteoporosis (bone density)medicine
[ ] Anticoagulants	[ ] Insulin or diabetes medication	[ ] Natural supplements
[ ] Antibiotics	[ ] Nitroglycerin	
[ ] HBP	[ ] Cortisone	

Have you ever been hospitalized for illness? Yes [ ] No [ ]

When: ______________________ Why: ______________________

For women only:

Are you taking Birth Control Pills? Yes [ ] No [ ]

Are you pregnant? Yes [ ] No [ ] If yes, # of weeks [ ]

Are you nursing? Yes [ ] No [ ]

Please check (✓) to indicate whether you have any of the following medical problems and include the date to indicate when the problem ocurred

Y	N	Conditions	Y	N	Conditions
[ ]	[ ]	Abnormal bleeding	[ ]	[ ]	Cholesterol
[ ]	[ ]	Alcohol Abuse	[ ]	[ ]	Colitis
[ ]	[ ]	Anemia	[ ]	[ ]	Congenital Heart Defect
[ ]	[ ]	Angina Pectoris	[ ]	[ ]	Cosmetic Surgery
[ ]	[ ]	Arthritis	[ ]	[ ]	Diabetes
[ ]	[ ]	Artificial bones	[ ]	[ ]	Difficulty Breathing
[ ]	[ ]	Artificial Heart Valve	[ ]	[ ]	Drug Abuse
[ ]	[ ]	Asthma	[ ]	[ ]	Emphysema
[ ]	[ ]	Blood Transfussion	[ ]	[ ]	Epilepsy
[ ]	[ ]	Cancer/ Chemotherapy	[ ]	[ ]	Fainting Spells
[ ]	[ ]	Fever Blisters	[ ]	[ ]	HIV+ AIDS
[ ]	[ ]	Frequent Headaches	[ ]	[ ]	Kidney Problems
[ ]	[ ]	Glaucoma	[ ]	[ ]	Liver disease
[ ]	[ ]	Hay Fever	[ ]	[ ]	Low Blood Pressure
[ ]	[ ]	Heart Attack	[ ]	[ ]	Mitral Valve Prolapse
[ ]	[ ]	Heart Surgery	[ ]	[ ]	Pace Maker
[ ]	[ ]	Hemophilia	[ ]	[ ]	Pneumocystitis
[ ]	[ ]	Hepatitis A	[ ]	[ ]	Psychiatric Problems
[ ]	[ ]	Hepatitis B	[ ]	[ ]	Radiation Therapy
[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Rheumatic Fever
[ ]	[ ]	Seizures	[ ]	[ ]	Gastric Bypass
[ ]	[ ]	Shingles	[ ]	[ ]	Heart Stents
[ ]	[ ]	Sickle Cell Disease			
[ ]	[ ]	Sinus Problems			
[ ]	[ ]	Stroke			
[ ]	[ ]	Thyroid problems			
[ ]	[ ]	Tuberculosis			
[ ]	[ ]	Ulcers			
[ ]	[ ]	Venereal Disease			
[ ]	[ ]	Yellow Jaundice			

Do you have other conditions/problems not covered above, if yes, describe below:

____

____

CONSENT FOR SERVICES

We feel that everyone benefits when there is definite and clear understanding of our treatment and financial policies prior to treatment. They are intended to allow us to be fair to our entire family of patients and help control administrative cost.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of 6 (six) months from the date of the patient examination.

Please be on time for reserved appointment. We have exclusively reserved the Doctor, Staff, and Facility for your personal dental care. We would appreciate your consideration in giving our office a 48 hour notice. If you didn't show up for an appointment you made, without sufficient notice, we reserve the right to charge a $50 per each ½ hour broken appointment fee.

We accept cash, personal checks, Visa, MasterCard, Discover, and American Express. We offer interest fee financing for qualified patients.

There is a $25 fee for any returned checks.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have received the notice of privacy practices and I have been provided an opportunity to review it.

Signature of patient, parent or guardian (responsible party) Date:

____

Relationship to Patient: ____

4651 N. State Road 7 Unit #4 Coral Springs, Fl 33073 Phone (954)510 4300

PHOTOGRAPHY RELEASE

I, ____

Hereby authorize Dr. Luis F. Gomez or his assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, Complete Dental Health website, social media (Facebook) and professional publications (Journals, Magazines).

I further understand that if the photographs, slides and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Agree ☐ Disagree ☐

____

Signature

Agreement to Receive Communication

Patient Name:____

(Initial below)

I ______ do agree

I ______ do not agree

I am aware that there is some level of risk that the third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of contact communication :

(Initial below)

________ Home phone ________ Cell phone ________ Work phone ________ Emergency contact phone

List the people you authorize us to release any dental records and information:

Name	Relationship:	Phone:

____

Signature

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