James Family Dentistry, P.A.
685 Royal Palm Beach Blvd. #204
Royal Palm Beach, Fl 33411
561-795-1978

Patient Information

First name: Last name:

Address:

City: State: Zip:

Home Phone Number: Cell Phone:

Work Phone Number: Email:

Social Security Number: Date of Birth:

Emergency Contact: Phone Number:

Insurance Policy Holder/ Responsible Party (if other than patient)

Name: Relationship to Patient:

Address:

City: St: Zip:

Social Security Number: Date of Birth:

Employer Name: Insurance Company:

Dental History

Previous Dentist:

Date of Last Exam/X-rays:

What is the reason for your visit today:

How Did You Hear About Us?

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO

Are you having any discomfort?	Yes	No
Do you snore?	Yes	No
Do you have bleeding gums?	Yes	No
Do you have bad breath?	Yes	No
Do you grind your teeth?	Yes	No
Do you play sports?	Yes	No
Are you sensitive to hot, cold or sweets?	Yes	No
Have you ever had any type of periodontal therapy?	Yes	No
Do you take a fluoride supplement?	Yes	No
Do you use tobacco?	Yes	No
Do you drink coffee or tea?	Yes	No
Are you interested in having whiter/brighter teeth?	Yes	No
Do you have difficulty brushing your teeth?	Yes	No

How would you rate your smile on a scale of 1 to 10, 10 being highest?

Dentures/Partials

Do you wear a denture or partial?	Yes	No

How old is your denture or partial?

Does your denture cause irritation or soreness?	Yes	No
Are your dentures loose?	Yes	No

Medical History

Are you under the care of a physician?	Yes	No

Physician Name: Phone Number:

Have you ever been hospitalized or had major surgery?	Yes	No
Have you ever had a serious head or neck injury?	Yes	No
Do you use any controlled substances?	Yes	No
Women: Are you pregnant, trying to get pregnant or nursing?	Yes	No

If you answered Yes to any of the above questions, please explain:

Are you allergic to or have an adverse reaction to any of the following?

Aspirin	Yes	No	**Acrylic**	Yes	No
Sulfa	Yes	No	**Penicillin**	Yes	No
Tetracycline	Yes	No	**Metal**	Yes	No
Barbituates	Yes	No	**Sedatives**	Yes	No
Codeine	Yes	No	**Latex**	Yes	No
Local Anesthesia	Yes	No	**Milk protein**	Yes	No

Other:

PLEASE CIRCLE YES OR NO IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS:

AIDS/HIV+	YES NO	**ALZHEIMER'S DISEASE**	YES NO
ANAPHYLAXIS	YES NO	**ANEMIA**	YES NO
ANGINA	YES NO	**ARTHRITIS/GOUT**	YES NO
ARTIFICIAL HEART VALVE	YES NO	**ARTIFICIAL JOINT**	YES NO
ASTHMA	YES NO	**BLOOD DISEASE**	YES NO
BLOOD TRANSFUSION	YES NO	**BREATHING PROBLEM**	YES NO
BRUISE EASILY	YES NO	**CANCER**	YES NO
CHEMOTHERAPY	YES NO	**CHEST PAINS**	YES NO
COLD SORES/FEVER BLISTERS	YES NO	**CONGENITAL HEART DISORDER**	YES NO
CONVULSIONS	YES NO	**CORTISONE MEDICATION**	YES NO
DIABETES	YES NO	**DRUG ADDICTION**	YES NO
EASILY WINDED	YES NO	**EMPHYSEMA**	YES NO
ENDOCARDITIS	YES NO	**EPILEPSY OR SEIZURES**	YES NO
EXCESSIVE BLEEDING	YES NO	**EXCESSIVE THIRST**	YES NO
FAINTING SPELLS/DIZZINESS	YES NO	**FREQUENT COUGH**	YES NO
FREQUENT DIARRHEA	YES NO	**FREQUENT HEADACHES**	YES NO
GLAUCOMA	YES NO	**HAY FEVER**	YES NO
HEART ATTACK/FAILURE	YES NO	**HEART MURMUR**	YES NO
HEART PACEMAKER	YES NO	**HEART TROUBLE/DISEASE**	YES NO
HEMOPHILIA	YES NO	**HEPATITIS A**	YES NO
HEPATITIS B OR C	YES NO	**HERPES**	YES NO
HIGH BLOOD PRESSURE	YES NO	**HIVES OR RASH**	YES NO
HYPOGLYCEMIA	YES NO	**IRREGULAR HEARTBEAT**	YES NO
KIDNEY PROBLEMS	YES NO	**LEUKEMIA**	YES NO
LIVER DISEASE	YES NO	**LOW BLOOD PRESSURE**	YES NO
LUNG DISEASE	YES NO	**MITRAL VALVE PROLAPSE**	YES NO
OSTEOPOROSIS	YES NO	**PAIN IN JAW JOINTS**	YES NO
PARATHYROID DISEASE	YES NO	**PARKINSON'S DISEASE**	YES NO
PINS,RODS,STENTS OR SHUNTS	YES NO	**PSYCHIATRIC CARE**	YES NO
RADIATION TREATMENT	YES NO	**RECENT WEIGHT LOSS**	YES NO
RENAL DIALYSIS	YES NO	**RHEUMATIC FEVER**	YES NO
RHEUMATISM	YES NO	**SCARLET FEVER**	YES NO
SHINGLES	YES NO	**SICKLE CELL DISEASE**	YES NO
SINUS PROBLEM	YES NO	**SPINA BIFIDA**	YES NO
STOMACH/INTESTINAL DISEASE	YES NO	**STROKE**	YES NO
SWELLING OF LIMBS	YES NO	**THYROID DISEASE**	YES NO
TONSILLITIS	YES NO	**TUBERCULOSIS**	YES NO
TUMORS OR GROWTHS	YES NO	**ULCERS**	YES NO
VENEREAL DISEASE	YES NO	**YELLOW JAUNDICE**	YES NO
NONE OF THE ABOVE			

PLEASE CHECK ANY MEDICATIONS AND/OR SUPPLEMENTS TAKEN IN THE PAST 12 MONTHS:

	ANTIBIOTICS OR SULFA DRUGS		**TRANQUILIZER**
	ASPIRIN (DAILY)		**CONTRACEPTIVES**
	INSULIN OR DIABETES MEDICATION		**NITROGLYCERINE**
	HERBAL SUPPLEMENTS		**HEART MEDICATIONS**
	ANTICOAGULANTS/BLOOD THINNERS		**PHEN-FEN OR REDUX**
	BISPHOSPHONATES, FOSAMAX, BONIVA, ACTONEL ETC. (USED TO TREAT OSTEOPOROSIS)		**HIGH BLOOD PRESSURE MEDICATION**

***NAMES OF ALL MEDICATIONS/SUPPLEMENTS YOUR ARE CURRENTLY TAKING:**_____

_____

_____

***HAVE YOU EVER HAD BOTOX, JUVADERM OR ANY OTHER INJECTABLE FILLERS PLACED?**_____

I have answered all questions to the best of my knowledge. I will notify the dental health provider of any changes in my health or medications at each visit.

I authorize the dentist/hygienist to use the necessary local/topical anesthesia to perform my treatment in a safe, effective manner during this visit and any future visits. I understand that my failure to provide information on previous adverse reactions may cause unforeseen negative reactions. I release James Family Dentistry, P.A. of all liability regarding undisclosed medical history information.

Our Practice uses email, sent from ciara@jamesfamilydentistry.com, to communicate with patients about the following:

Surveys: asking your opinion regarding your experience at our Practice.

Office Information: (*including but not limited to*) information about changes to office hours, holiday schedules, and weather delays.

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

If authorized guardian, name & relationship **Witness Signature**

_____ _____

Dentist Signature **Date**