AMELIA DENTAL GROUP

COMPREHENSIVE DENTISTRY

1947 Citrona Drive ■ Fernandina Beach, Florida 32034 ■ T 904.261.7181 F 904.261.9797

www.ameliadental.com

Office use:
Patient #

# ADULT

## PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| Patient Last Name | Patient First Name | MI | Preferred Name | |
| Mailing Address | City | State | Zip Code | |
| Home Phone | Work Phone | Cell Phone | Best time to call | |
| Birth Date | SS # | DL # | Sex | Marital Status |
| Whom may we thank for referring you to our office. | | Name of other family members who are patients: | | |
| Employer | Spouse's Name | Spouse's Employer | | |
| Email address | | Nearest Relative not living with you | | |

## RESPONSIBLE PARTY | ❑ Same as above

| | | | |
|---|---|---|---|
| Last Name | First Name | MI | |
| Mailing Address | City | State | Zip Code |
| Home Phone | Work Phone | Cell Phone | |
| Birth Date | SS # | DL # | Relationship to Patient |

## DENTAL INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Policy Holder Last Name | First Name | MI | |
| Mailing Address | City | State | Zip Code |
| Home Phone | Work Phone | Cell Phone | |
| Birth Date | SS # | DL # | Relationship to Patient |
| Employer | | Insurance Company | |
| Complete mailing address of Insurance Company | | | |
| Telephone Number of Insurance Company | Group # | Subscriber ID | |

Office use:
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**PATIENT NAME** _____

## THERE ARE MANY MEDICAL SITUATIONS WHICH CAN AFFECT OR BE AFFECTED BY PROCEDURES OR DRUGS USED FOR DENTISTRY. THEREFORE, PLEASE FILL OUT THE FOLLOWING CAREFULLY. THANK YOU.

| Date of last medical exam | Physician's Name | Phone |
|---|---|---|
| | | |

**MEDICAL HISTORY**

# ADULT

**PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:**

Heart Disease/Surgery
Irregular Heart Beat
Angina/Chest Pain
Heart Attack/Heart Failure
Congenital Heart Disorder
Bacterial Endocarditis
Rheumatic Fever
Artificial Heart Valve
Pacemaker
Stroke
Low Blood Pressure
High Blood Pressure
Bruise Easy/Blood Disease
Excessive Bleeding
Anemia

Hemophilia
Leukemia
Lung Disease
Asthma
Emphysema
Breathing Problem
Tuberculosis
Hayfever/Allergies
Sinus Troubles
Cancer
Radiation Treatment
Chemotherapy
Ulcer/Colitis
Chronic Diarrhea
Acid Reflux

Chronic Fatigue
Diabetes
Liver Disease
Hepatitis
Kidney Disease/Dialysis
Thyroid Disease
Arthritis
Artificial Joint
Osteoporosis
Neurological Problem
Epilepsy/Seizures
Alzheimers
Memory Loss
Fainting/Dizzy Spells
Depression

Psychiatric Care
Sleep Apnea/Snoring
Facial Plastic Surgery
Eye Disorder
Latex Allergy
Metal Allergy
Pregnancy
Herpes
HIV+
Venereal Disease
Excessive Thirst
Dry Mouth
Eating Disorder

| |
|---|
| Are you allergic to any medicine or local anesthetic? ❑ Yes ❑ No<br>If yes, Please list: |
| Are you taking any medications? ❑ Yes ❑ No<br>If yes, Please list: |
| Are currently receiving medical treatment? ❑ Yes ❑ No<br>If yes, Please list: |
| Is there any other medical information which should be known? |

| Date of last dental exam | Any previous major dental treatment? ❑ Yes ❑ No<br>If yes, when? |
|---|---|

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? - CHECK YES OR NO**

❑ Yes ❑ No Bad Breath
❑ Yes ❑ No Unpleasant taste
❑ Yes ❑ No Food impaction
❑ Yes ❑ No Mouth breathing
❑ Yes ❑ No Clinching or grinding
❑ Yes ❑ No Burning of tongue
❑ Yes ❑ No Bleeding gums
❑ Yes ❑ No Pain around ear
❑ Yes ❑ No Swelling/lumps in mouth
❑ Yes ❑ No Unfavorable dental experiences
❑ Yes ❑ No Fingernail biting, thumb sucking, bottle nursing
❑ Yes ❑ No Are you happy with the appearance of your teeth?

❑ Yes ❑ No Periodontal treatment
❑ Yes ❑ No Orthodontic treatment
❑ Yes ❑ No Frequent blisters on lips or mouth
❑ Yes ❑ No Unusual sounds in ear while eating
❑ Yes ❑ No Disclosing tablets or solution
❑ Yes ❑ No Fluoride supplement
❑ Yes ❑ No Water jet device
❑ Yes ❑ No Do you use inter dental stimulators?
❑ Yes ❑ No Complications from extractions
❑ Yes ❑ No Cigarettes, pipe or cigar smoking, chewing tobacco
❑ Yes ❑ No Teeth sensitive to cold, heat, sweets or pressure

Please answer the following:

What is the texture of your toothbrush? _____

How often do you brush? _____

How often do you floss? _____

Reason for seeking a New Dentist: _____

Is there anything that you would like to change about your smile? _____

**Appointments you select are reserved especially for you. Since "late cancellations" and "no shows" deny other patients the opportunity to schedule needed care, cancellations less than 24 hours in advance may be charged a cancellation/no show fee.**

I hereby certify that the information provided on this form is true and correct.

Signature _____ Date: _____

Reviewed by: _____ DDS / DMD Date: _____