victoria L.
{ADAMS dmd
healthy gums for healthy lives.

Date: _____

Patient Information

Patient Name _____ SS # _____

If minor, Parent/Guardian Name _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Office _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Employer/School _____ Occupation _____

Spouse _____ Employer _____

Whom may we thank for referring you _____

In case of emergency who should be notified? _____ Phone _____

Primary Dental Insurance

Cardholder Name _____

Relation to Patient _____ Birthdate _____ SS# _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Cardholder Employed by _____

Insurance Company _____ Phone _____

Insurance Company Address _____

Subscriber/ID # _____ Group # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____.

I understand that I am financially responsible for all charges. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) for determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature Date

_____ _____
Please print name of Patient, Guardian or Personal Representative Relation to Patient

28469 US 19 North, Suite 401, Clearwater, FL 33761
{web} churneyperio.com {email} info@churneyperio.com {phone} 727-799-6733 {fax} 727-726-9157

Over ⇨

Dental History

Reason for Today's Visit _____

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

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Dry Mouth
- ☐ Food Collection between teeth
- ☐ Grinding teeth
- ☐ Gum Recession
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

Medical History

Physician's Name _____ Phone _____ Date of Last Visit _____

Have you had any serious illnesses, hospitalizations or operations? _____ If yes, describe _____

_____

Do you or have you in the past taken bisphosphonates or RANK-L inhibitors (Aredia, Actonel, Boniva, Fosomax, Prolia, Reclast, Zometa)? ☐ Yes ☐ No

Do you pre-medicate for dental procedures? ☐ Yes ☐ No Are you on Blood Thinners (Coumadin, Plavix)? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

- ☐ Anemia
- ☐ Angina
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chemical Dependency
- ☐ Circulatory Problems
- ☐ Other _____
- ☐ Clostridium Difficile Colitis
- ☐ Congenital Heart Disease
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Fainting
- ☐ GERD
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Infective Endocarditis
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Health Condition
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
- ☐ Osteoporosis
- ☐ Pacemaker / Implated Defibrillator
- ☐ Prosthetic Joint Infection
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Scleroderma
- ☐ Shortness of Breath
- ☐ Sjorgen's
- ☐ Skin Rash
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit (current/past)
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Vitamin D Deficiency

Medications

List medications you are currently taking:

_____

_____

Preferred Pharmacy Name _____

Phone (_____) _____

Allergies

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin or other antibiotics
- ☐ Sulfa
- ☐ Latex
- ☐ Other _____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____