ADMIRA DENTISTRY

BEAUTY · HEALTH · BALANCE

4152 Baymeadows Road • Jacksonville, FL 32217 •904.733.9144 Tel. • 904.739.2304

Guest Information

Name: _____ ☐Mr. ☐Mrs. ☐Ms. ☐Dr. Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Soc. Sec #: _____ Birthdate: _____ Home Phone: _____

Cell: _____ Email: _____ Contact Preference: _____

Employer: _____ Occupation: _____ Work Phone: _____

Spouse Name: _____ Employer: _____ Work Phone: _____

If Student, School/College: _____ City: _____ State: _____ ☐Full Time ☐Part Time

Person to Contact in Case of Emergency: _____ Relationship: _____ Phone: _____

Whom May We Thank for Referring You? _____

Responsible Party (if someone other than guest)

Name of Person Responsible for this Account: _____ Relationship: _____

Address: _____ Contact #: _____

Birthdate: _____ Soc. Sec #: _____ Employer: _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash/Check ☐ Debit Card ☐ Visa ☐ MasterCard ☐ Discover ☐ Amex ☐ HSA/FSA Card

Guest Dental Health

Name of Previous Dentist: _____ Date of Last Cleaning: _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you had any ortho (braces) treatment?	☐	☐
12. Do you have any missing teeth?	☐	☐
13. Are you having any dental problems that require immediate attention?	☐	☐
14. Do you have any noticeable wear on your teeth?	☐	☐
15. Any unwanted spacing?	☐	☐
16. Have you ever had an unpleasant dental experience?	☐	☐

17. How do you feel about the appearance of your smile? _____

_____

18. If you could change anything about your smile, what would it be? _____

_____

_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you currently under a physicians care? ○ Yes ○ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____

Are you taking any medications, pills or drugs? ○ Yes ○ No If yes, please list: _____

Do you take or have you taken Phen-Fen or Redux? ○ Yes ○ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No If yes, please explain: _____

Do you use tobacco? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No If yes, please list: _____

Women: Are you
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Convulsions	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Easily Winded	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Emphysema	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Leukemia	○ Yes ○ No	Intestinal Disease	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Glaucoma	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsilitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Hay Fever	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
		Heart Pacemaker	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
		Heart Trouble/Disease	○ Yes ○ No			Yellow Jaundice	○ Yes ○ No

Have you ever had a serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or guest's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF GUEST, PARENT, or GUARDIAN_____DATE_____

SIGNATURE OF DENTIST _____DATE_____