CAYO COSTA DENTAL

Patient Information

Date / /

O(Mr) O(Mrs) O(Miss) O(MS)

Last Name	**First Name**	**Middle**
Mailing Address		
Phone Number	**Cell**	**Emergency Contact**
DOB		

Email Address:
Last Dental Visit:
Reason for Today's Visit:

Do You Have Dental Insurance?: **Yes** **(complete Section A)** **No**

Section A

Subscribers Full Name	**Subscribers DOB**	**Subscribers Social Security Number**
Insurance Company		**Employers Name**
Carriers Address		
Carriers Phone Number	**Group Number**	**Relationship to Patient**

Who can we thank for the referral? _____

I authorize release of dental service directly to my insurance company from Cayo Costa Dental. I also authorize the release of any information necessary to my insurance company to process any and all claims on my behalf. I agree to pay my charges in full at time of service unless other arrangements have been made prior to my appointment. If this account is placed for collection, a valid collection fee and 18% interest will be added to your balance.

Patient Signature:	**Date:**	
Parent or Guardian Signature:	**Date:**	**Relationship:**

CAYO COSTA DENTAL
Dr. Frederick J. Fox III

MEDICAL HISTORY FORM

Name:_____

DOB:_____

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. Please read and answer all questions to the best of your ability.

Do you have anxiety or fear of the Dentist? O Yes O No
Would you consider Oral Sedation (Anxiolsyis) O Yes O No

Are you under a physician's care now? O Yes O No Reason:_____
Have you ever been hospitalized? O Yes O No When:_____
Have you had any major surgeries? O Yes O No Type:_____
Have you had any neck or head injuries? O Yes O No When:_____
Are you on a special diet? O Yes O No Type:_____
Do you use tobacco? O Yes O No
Do you use controlled substance? O Yes O No

Do you pre-medicate prior to dental treatment? O Yes O No Medication: O Amoxicillin O Clindamycin O Keflex

Women: Are you

O Pregnant/Trying to get pregnant?	O Nursing?
O Taking any form of birth control?	O Could you possibly be pregnant?

Are you allergic to any of the following:

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Demerol O Sulfa O Tetracycline

O Other if yes, please explain:_____

Do you have jaw pain/headaches/earaches? O Yes O No
Do you wear a night time appliance? O Yes O No if yes, Explain type:_____

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

O AIDS/HIV Positive	O Chest Pain	O Frequent Headaches	O Irregular Heartbeat	O Scarlet Fever
O Alzheimer's Disease	O Cold sores/Fever blisters	O Genital Herpes	O Kidney Problems	O Shingles
O Anaphylaxis	O Congenital Heart Disorder	O Glaucoma	O Leukemia	O Sickle Cell Disease
O Anemia	O Convulsions	O Hay Fever	O Liver Disease	O Sinus trouble
O Angina	O Cortisone Medicine	O Heart attack/Failure	O Low Blood Pressure	O Spina Bifida
O Arthritis/Gout	O Diabetes	O Heart Murmur	O Lung Disease	O Stomach/Intestinal Disease
O Artificial Heart Valve	O Drug Addiction	O Heart Pace Maker	O Mitral Valve Prolapse	O Stroke
O Artificial Joint	O Easily Winded	O Heart Trouble/disease	O Pain in Jaw Joints	O Swelling of limbs
O Asthma	O Emphysema	O Hemophilia	O Parathyroid Disease	O Thyroid Disease
O Blood Disease	O Epilepsy or Seizures	O Hepatitis	O Psychiatric Care	O Tonsillitis
O Blood Transfusion	O Excessive Bleeding	O Hepatitis B or C	O Radiation Treatment	O Tuberculosis
O Breathing Problems	O Excessive Thirst	O Herpes	O Recent Weight Loss	O Tumors or Growth
O Bruise Easily	O Fainting Spell/Dizziness	O High Blood Pressure	O Renal Dialysis	O Ulcers
O Cancer	O Frequent Cough	O Hives or Rash	O Rheumatic Fever	O Venereal Disease
O Chemotherapy	O Frequent Diarrhea	O Hypoglycemia	O Rheumatism	O Spleen problems/removal
O Dry Mouth	O Drink Alcohol: Amount_____		O Osteoporosis	

Have you ever had any serious illness not listed above? O Yes O No if yes, please explain: _____
_____

Have you ever taken Bisphosphonates?: O Yes O No Type:_____

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MEDICAL HISTORY FORM

Please List all Medications: (Including all natural remedies and vitamins)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Physician:
Name:_____
Phone Number:_____
Date of last physical?:_____

Specialist:
Name:_____
Phone Number:_____
Date of last visit?_____

Pleas list any other doctors names and numbers in comment book below:
Comments:

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 patients) health. It is my responsibility to inform the dental team office of any changes in medical status.

Signature of Patient/Parent/ Guardian:_____ Date:_____

Update:_____ Signature:_____
Any Changes in Medication/Health: O Yes O No List:_____
_____
Address Change: O Yes O No _____

Update:_____ Signature:_____
Any Changes in Medication/Health: O Yes O No List:_____
_____
Address Change: O Yes O No _____

Update:_____ Signature:_____
Any Changes in Medication/Health: O Yes O No List:_____
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