ATLANTIC FLORIDA DENTAL , INC.
WELCOMES YOU

DATE _____ **E-MAIL ADDRESS**_____

Last Name_____ First Name _____ M.I. _____

Home Address_____

City _____ State _____ Zip _____ Date of Birth _____

Home Telephone _____ Cell # _____ Age _____

Sex: (circle) Male or Female Marital Status: Single, Married, Divorced, Separated, Widowed

Social Security Number_____ DR, Lic # _____

Employed By_____ Business phone _____
Business address _____

Person to call in case of Emergency: Name _____ Relationship _____ Phone _____

How are you paying for today's appointment? CASH CHECK CREDIT CARD INSURANCE OTHER

HOW DID YOU HEAR ABOUT OUR OFFICE? PATIENT TV ONLINE NEWSPAPER OTHER

ARE YOU UNDER ANY HMO OR PPO PLAN? YES NO NAME OF PLAN _____

GENERAL HEALTH QUESTIONS

1. Do you have or have you had any of the following ? Please Circle the condition:

Heart Attack/ Heart Trouble	Thyroid Disease	Open Heart Surgery
Mitral Valve Prolapse	Congenital Heart Disease	Valve Replacement
Rheumatic Fever/Murmur	Anemia/ Blood Disorders	Nervous Disorder
Blood Pressure (HIGH OR LOW)	Arthritis / Night Sweats	Asthma / Hay Fever / Emphysema
Stroke / Kidney Disease	Diabetes / Fainting	Glaucoma/ Tumors or Growths
Extreme Weight Loss/ Anorexia	Migraine Headaches	Hepatitis / Liver Disorders
Ulcers / Prostate Problems	Cancer Treatment	Radiation or Chemotherapy
Persistent Cough	Herpes	HIV Positive
Allergic to Nickel or other Metals	Venereal Disease	Palpitations
TMJ Problems	Periodontal Surgery	Pregnant # Of Months _____

ARE YOU ALLERGIC TO LATEX ? YES NO

Initials of DDS reviewing Medical HX _____

2. Are you under the care of a Physician at this time? YES NO
   If yes why ? _____

3. Are you taking any Drugs or Medications at this time? YES NO
   If yes name and dosage of each _____
4. Blood Thinners or Cortisone-Like YES NO
5. Are you allergic or reacted aversely to any medication, food, or anesthetic YES NO
6. Have you ever had a Knee or Joint Replacement or Pin inserted? YES NO
7. Have you ever had any Bleeding or Clotting ps