EVERY SMILE IS BEAUTIFUL

DENTAL IMPLANT CENTER OF FLORIDA

Tel: (813) 528-8900
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www.dentalimplantflorida.com

We are pleased you have selected us to provide dental care for you and your family!
Whom may we thank for referring you to our office? _____

Patient Information

Today's Date _____

Patient Name _____
First Last

Phone (Home): _____ (Cell): _____ (Work): _____

Address: _____
Street City State Zip

Email Address: _____ Social Security: _____

Birth Date: _____ Sex: ◯M ◯F Parent's/Guardian's Name if minor: _____

Occupation: _____ Patient Employer/School: _____

Insurance Information

Insured's Name: _____ Insured's SS#: _____ Insured's DOB: _____

Insurance Company: _____ Phone #: _____

Insured's Employer: _____ No. Years Employed: _____

Is this the first time using the insurance for the above patient? Yes ◯ No ◯

Dental History

Reason for today's visit: _____

Date of last dental visit: _____ What was done at the time? _____

Dentist Name: _____ City/State: _____

How often do you brush? _____ How often do you floss? _____

Medical History

Are you having pain or discomfort at this time? Yes ◯ No ◯

If yes, please explain: _____

Do you have any medical conditions? Yes ◯ No ◯

If yes, please explain: _____

Have you been hospitalized during the last two years? Yes ◯ No ◯

If yes, please explain: _____

Are you taking any medications at this time? Yes ◯ No ◯

If yes, please explain: _____

Are you allergic to any medication/anesthetics/latex? Yes ◯ No ◯

If yes, please explain: _____

Have you ever had any complications following dental treatment? Yes ◯ No ◯

If yes, please explain: _____