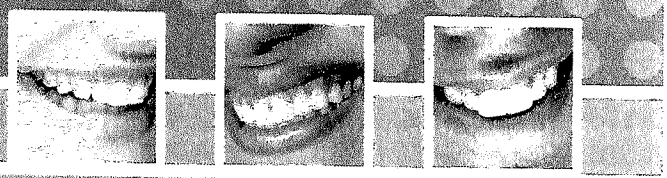
Pediatric Dentistry of New Tampa, Inc.
5326 Primrose Lake Circle
Tampa FL 33647

(813)374-0388



Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Are you currently taking any prescription or non-prescription medications?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

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Please indicate if you have experienced any of the following:

- ☐ ADHD
- ☐ Allergies
- ☐ Autistic
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ Jaundice
- ☐ Mitro Valve
- ☐ Premed
- ☐ Rheumatic Fever
- ☐ Rx - Albuterol
- ☐ Rx-Singulair
- ☐ Rx-Straterra
- ☐ Stroke
- ☐ Ulcers
- ☐ Allergic-Amoxicillin
- ☐ Anemia
- ☐ Blood Disease
- ☐ Downs Syndrome
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Kidney Disease
- ☐ Nervous Disorders
- ☐ Present Meds - notes
- ☐ Rheumatism
- ☐ Rx - hydrocortisone
- ☐ Rx-Straterra
- ☐ Sinus Problems
- ☐ Sulfa Drugs
- ☐ Venereal Disease
- ☐ Allergic-Augmentin
- ☐ Arthritis
- ☐ Cancer
- ☐ Eczema
- ☐ Growths
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Other
- ☐ Radiation Treatment
- ☐ RSV
- ☐ Rx-Concerta
- ☐ Rx-Straterra
- ☐ Sleep Apena
- ☐ Tuberculosis
- ☐ Allergic-Zithromax
- ☐ Asthma
- ☐ Codeine Allergy
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Mental Disorders
- ☐ Penicillin Allergy
- ☐ Respiratory Problems
- ☐ Rx - Advair
- ☐ Rx-Ritalin
- ☐ Rx-Straterra
- ☐ Stomach Problems
- ☐ Tumors

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

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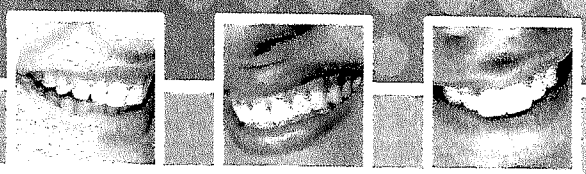

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2 - 6 weekly ○ 1 - 6 monthly ○ Seldom ○ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

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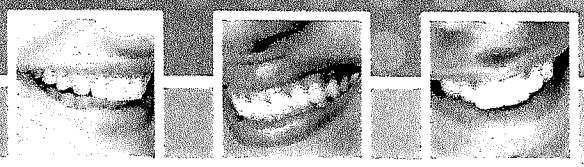

If you could change anything about your mouth, teeth, or smile, what would it be?

*☐ To the best of my knowledge, all of the preceding information is true and accurate. If my child, the patient or I ever have a change in health, I will inform the office at the next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health, the health of my child, or the health of the patient..

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist and/or Pediatric Dentistry of New Tampa, Inc. to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or Pediatric Dentistry of New Tampa, Inc. to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

*☐ By checking this box, I acknowledge the above statement.

Signature and Relationship to Patient:

Response Date: