D. Georgina Garcia, D.M.D. , P.A.

GENERAL DENTISTRY

407 Lincoln Road · Suite 8A · Miami Beach, Florida 33139 · 305-538-2088

PATIENT NAME_____ DATE _____

SOCIAL SECURITY # _____ DATE OF BIRTH: _____ SEX ____ HEIGHT _____ WEIGHT _____

HOME ADDRESS _____
Street Apt # City State Zip Code

HOME PHONE: _____ WORK PHONE: _____ CELLULAR: _____

E-MAIL:_____ EMPLOYER: _____ OCCUPATION_____

BUSINESS ADDRESS: _____

CLOSE RELATIVE _____ RELATION _____ TELEPHONE _____

IF YOU ARE FILLING UP THIS APPLICATION, WHAT IS YOUR RELATIONSHIP TO THE PATIENT? _____

REFERRED BY: _____ RESPONSIBLE PARTY FOR CHARGES: _____

INSURANCE PLAN? YES☐NO ☐ INSURANCE COMPANY _____
POLICY # _____ GROUP # _____ INSURED NAME _____

IF INSURED IS OTHER THAN THE PATIENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

INSURED EMPLOYER _____ INSURED SS# _____ INSURED DATE OF BIRTH _____

DENTAL HISTORY

		YES	NO
1.	Do you clench or grind your teeth?	☐	☐
2.	Have you been under regular care by a dentist?	☐	☐
3.	Have you ever had any teeth extracted?	☐	☐
	* Were there any complications involved?	☐	☐
4.	Do any of your teeth ache?	☐	☐
5.	Do your gums feel tender or swollen?.....	☐	☐
6.	Do your gums bleed when you brush?.....	☐	☐
7.	Does food catch between your teeth?.....	☐	☐
8.	Do you have any loose teeth?.....	☐	☐
9.	Are you nervous about going to the dentist?.....	☐	☐
10.	Have you ever had a bad dental experience?	☐	☐
	If yes, explain: _____		
	_____		
11.	What dental problem do you have now?_____		
	_____		
	_____		
12.	Have you ever had an allergic reaction to any medication given by a dentist?.....	☐	☐
	If yes, which one? _____		

MEDICAL HISTORY

Your answers to the following questions are for our records only and will be considered confidential

		YES	NO
1.	Are you in good health?	☐	☐
2.	Has there been any change in your general health within the past year?	☐	☐
3.	My last physical examination was on _____		
4.	Are you under the care of a physician?	☐	☐
5.	The name and address of my physician is: _____		
	_____		
6.	Have you had any serious illness or operation?	☐	☐
7.	Have you been hospitalized or had a serious illness within the past five years ?.....	☐	☐
	If yes to question 6 and/or 7, explain: _____		
	_____		
	_____		
8.	Do you have chest pain upon exertion?	☐	☐
9.	Are you ever short of breath after mild exercise?	☐	☐
10.	Do your ankles swell?	☐	☐
11.	Do you get short of breath when you lie down or require additional pillows when you sleep?	☐	☐
12.	Do you or have you ever been told that you have a heart murmur?	☐	☐
13.	Do you have a cardiac pacemaker?	☐	☐
14.	Do you have or have you had any of the following illnesses or problems?	☐	☐
a.	Damaged heart valves or artificial heart valves?.....	☐	☐
b.	Congenital heart lesions?.....	☐	☐
c.	Cardiovascular disease ? (Heart trouble, heart attack, high blood pressure, arteriosclerosis, embolism, coronary insufficiency/occlusion)	☐	☐
d.	Rheumatic fever?	☐	☐
e.	Allergies?	☐	☐
f.	Sinusitis?.....	☐	☐
g.	Asthma or hay fever?	☐	☐
h.	Hives or skin rashes?	☐	☐
i.	Fainting spells or seizures?	☐	☐
j.	Diabetes?	☐	☐

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	YES	NO
k. Hepatitis, jaundice or liver disease?	☐	☐
l. Arthritis?	☐	☐
m. Inflammatory rheumatism (painful or swollen joints)	☐	☐
n. Stomach ulcers?	☐	☐
o. Kidney problems?	☐	☐
p. Tuberculosis?.....	☐	☐
q. Persistent cough or cough up blood?	☐	☐
r. Low blood pressure?.....	☐	☐
s. Venereal disease?.....	☐	☐
t. Other diseases?.....	☐	☐

* If yes, please explain:_____

_____

15. Have you had abnormal bleeding associated with previous extractions, surgery or trauma?	☐	☐
16. Do you bruise easily?	☐	☐
17. Have you ever required a blood transfusion?	☐	☐

If yes, explain the circumstances_____

_____

_____

18. Do you have any blood disorder such as anemia?	☐	☐
19. Have you had surgery or X-ray treatment for a tumor, growth or condition to your head or neck?	☐	☐
20. Are you employed in any situation which exposes you regularly to X-rays or other ionizing radiation?...	☐	☐
21. Are you wearing contact lenses?.....	☐	☐
22. Do you smoke?	☐	☐

	YES	NO
23. Are you allergic or have you reacted adversely to:		
a. Local anesthetics?.....	☐	☐
b. Penicillin or other antibiotics?.....	☐	☐
c. Sulfa drugs?	☐	☐
d. Barbiturates, sedatives or sleeping pills? ...	☐	☐
e. Aspirin?	☐	☐
f. Iodine?	☐	☐
g. Codeine or other narcotics?	☐	☐
h. Other?	☐	☐
24. Are you taking any of the following?		
a. Antibiotics o sulfa drugs?.....	☐	☐
b. Anticoagulants (blood thinners)?	☐	☐
c. Medicine for high blood pressure?	☐	☐
d. Cortisone or steroids?	☐	☐
e. Tranquilizers?.....	☐	☐
f. Antihistamines?.....	☐	☐
g. Aspirin?	☐	☐
h. Insulin, similar drug?	☐	☐
i. Digitalis or drugs for heart problems?.....	☐	☐
j. Nitroglycerin?	☐	☐
k. Oral contraceptives or hormonal therapy?...	☐	☐
l. Medicine for Osteoporosis like Boniva, Actonel, Fosamax, Zometa, Aredia?.....	☐	☐

H. Other:_____

WOMEN

25. Are you pregnant or could be pregnant?.....	☐	☐
26. Last menstrual period _____		
27. Do you have any problems with associated with your menstrual period?	☐	☐
28. Are you nursing?	☐	☐

It is very important that you advise the dentist and/or her dental assistants if you have any disease or condition not indicated above that you think that we should know in order to adopt additional precautions to protect your health.

_____

_____

My signature indicates that I have read and completely understood all the questions above.

_____ _____ _____

Signature of patient | Driver's License # | Date

_____ _____

Signature of dentist | Date

Consent for Treatment

This is to verify that I, the undersigned, hereby authorize Dr. D. Georgina Garcia to perform whatever examination, operation or treatment deemed necessary, and to the use of a local anesthetic as indicted and that the medical history I have provided is correct.

On rare occasions, some unusual, unexpected and severe reactions or complications may occur, but we feel it would be impractical and misleading to describe in detail all those that could arise during or following treatment.

Patients with Insurance: To avoid misunderstanding regarding insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies upon receipt of full (or partial) payment of the bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patients.

My signature indicates that I have read the above statement and that I fully understand the questionnaire.

_____ _____

Date Signature of Patient

_____

Signature of Dentist

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PLEASE LIST ALL PRESCRIPTION MEDICINES WHICH YOU ARE PRESENTLY TAKING:

PRESCRIPTION MEDICINE	DOSE / FREQUENCY	TIME OF DAY TAKEN