Gentle Dental Family Dentistry Inc. **2800 66th Street North**
Dr. Gabriele Spinuso, D.D.S. **St. Petersburg, FL. 33710**

Web: Drspinuso.com Email: Drspinuso@hotmail.com Office: (727) **302-9401 Fax: (**727) **388-2738** Emgcy #: (727) **688-4327**

* Date: ____/____/ 20_____ **Thank- you for selecting our Dental Healthcare Team** **Pa. #:** ______________

We will strive to provide you with the very best dental care possible.
Please complete and sign both sides of this form at the " X' s

Patient Information -- (confidential): NAME:____
(First) (M.I.) (Last)

Age: ________ Birthday: _______/_______/_______ Home#: (________)________-____________ Cell# : (________) ________-__________ OK to Text ☐

Email: ____ OK to Email ☐

ADDRESS: ____ City: _______________________ State: ______ Zip: ____________

Check appropriate: Minor (__) Single (__) Married (__) Divorced (__) Widowed (__) Separated (__) Student's School/College: ______________________

Patient's or Parent's Employer: ____City: _______________ Work#: (________) ________-______________

Spouse or Parent's Name: __________________________________ Employer: ______________________ Work#: (________) ________-______________

**** Whom may we thank for referring you?*** ____

Emergency Contact: NAME: _______________________ ___________________________ Phone #: (________) ________-______________
(First) (Last)

Relationship to Patient: ____________________________________ Cell#: (________) ________-_____________Work #: (________) ________-_________

Name of Responsible Party: ____ Relationship to Patient: ___________________________

Address: ____ City: ____________________ State: _________ Zip: ____________

Driver's License #: __________________________________ Birth Date: _______/________/____________

Insurance Information: ********* [OFFICE USE ONLY] *********

Name of insured:____ Relationship to Patient: _____________ DOB: ___________SS#:____________________

Member Id:_____________________ Employer:____ Grp# _________________ Effective : _________________

Insurance Company:______________________________ Tel.#___________________ Payor I.D #________________ Fee Schedule________________________

Ins. Co. Address:____ City:_____________ ________ State: ________ Zip:_______________

Deductible:_________ Annual Max:___________ Cal Yr.____ Physical Yr._____ Waiting Pd:______ Miss Tooth Cls: _____Fam Ded:________ Ded Waived:Prev ______

Basic______ Major_______ Secondary Ins: Yes____ No ___ Preventative: ______ % Basic:______% Major:______% Endo:______% Perio:_______% O.S.:______%

Debridement: ________ % Exam Freq:_________ History:__________ FMX / Pano Freq:_________ History:________ Bwx Freq:________ History:_____________

Prophy Freq: __________ History: _______ Fluoride Freq:__________ To Age: ________ Debridement freq : __________Count against Prophy ___________

Acknowledge of receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for
Gentle Dental Family Dentistry Inc., Dr. Gabriele Spinuso, DDS

This ____________ day of__________________, 20_______. Acopy of this signed and dated acknowledgment shall be as effective as the original

____ _X____
Printed Name Signature

If you are the legal representative of the patient, please print the patient's name and describe your authority:____

Thank you, if you have any questions about this form or the attached Notice, please contact our Privacy Officer or Myself.

-- ***Office use only*** --

As Privacy Officer, I attempted to obtain the patient's or representative's signature on this Acknowledgment but did not because:

____It was an emergency treatment ____I could not communicate with the patient. ____The patient refused to sign

The patient was unable to sign because: ____Other (please describe): ____________________________________

*Privacy Officer Signature*____

Name: ______________________ **Medical Alerts:** ______________________ **Patient ID #:** ____________

Patient: ______________________________ **Age:** __________ **Allergy:** __________________

Patient Medical History

Physician: ____________________________ Office #: (_______) _______-________ Blood Pressure: ------/-------- Last Examination: _____/_____/_______

Pharmacy Name: ____ Tel #: (______) _______ - ______________

1. Are you under medical treatment now? Y___ N___
Describe: ____
____
____

2. Ever been hospitalized for any surgical operations or serious illness?
List: ____
____
____

3. Taking any medications? (Prescription or Over the Counter) Y___ N___
If yes, what medications / amounts: _______________________________
____
____
For what condition(s): ____
____
____

4. Do you use tobacco? Y_____ N_____

5. Do you use: Alcohol _____ Cocaine _____ Other Drugs_____
List: ____

6. Are you allergic to/ or had a reaction to any of the following?
Local anesthetics (ex. Novocaine): Y _____ N_____
Penicillin: Y _____ N_____
Sulfa Drugs: Y _____ N_____
Barbiturate: Y _____ N_____
Other Antibiotics: ______________________________
Sedatives: Y _____ N_____
Iodine: Y _____ N_____
Aspirin: Y _____ N_____
Other meds: ___________________________________

7. Women Only:
Pregnant?(____) Nursing?(____) Birth Control Pills?(____)

8. Are you wearing contact lenses? Y____ N_____

9. **Do you have or have you ever had any of the following? (Check all that apply, give details as needed)**

High blood pressure: ____ Controlled? _____

Low blood pressure: ____ How low? ____/____

Heart Disease: ____

Heart attack: ____ When: ___________

Stroke: ____ When: __________________

Angina/chest pain: ____ Last Time? _________
(Do you have Nitroglycerin tablets): _______

Cardiac pace maker: _____

Rheumatic fever: ____ (Require antibiotic prophylaxis prior to dental treatment?): ______

Heart murmur: ____ (Require antibiotic prophylaxis prior to dental treatment?): ______

Frequently tired: ____

Swollen ankles: ____

Epilepsy / Convulsions: ____
Last time: ________ meds: _________________

Fainting / Seizures: ____ Last time: ________
Duration: ______________

Arthritis: ____

Liver disease: ____

Glaucoma: ____

Respiratory problems: _____

Tuberculosis: ____

Emphysema: ____

Hay fever allergies: _____

Easily winded: ____

Asthma: ____ Carry an Inhaler? _____
Last time used? _________Worked Ok? ______

Cancer: ____ When: _____________________
Where/Type: ______________________________
Treatment / Medications: ___________________
____
____
____

Leukemia: ___ Treatment: _________________

Radiation therapy: ____ How long ago? ______
Reason? _________________________________
Amount given? ____________________________

Recent Weight Loss: _____

Diabetes: ____ Type: _______ Last A1C:______
Meds: ___________________________________

Kidney disease: ____

Hepatitis / Jaundice: ____ (Type): ___________
Medications: ______________________________

Joint replacement: ______ (Require antibiotic prophylaxis prior to dental treatment?): ________

Implant: _____ (Require antibiotic prophylaxis prior to dental treatment?): _______

AIDS or HIV infections: ______
(Medications / Dosage_______________________
____

Sexually transmitted diseases: ____
Describe/List: _____________________________
Medications: ______________________________

Thyroid problems: ______
Medications: ______________________________

Stomach troubles / ulcers: _____
Medications: ______________________________

Bisphosphonates therapy (ex. Fosamax, Boniva…IV Meds… etc.): ______
List: _____________________________________

****Please explain/elaborate further on any conditions above:**______________________________

X ____ **Date** _____/___/______
Signature of Patient or (Parent/Guardian if Minor)

Medical History Update:

Date	*Comments*	*Pt. Initials*	*Dr. Initials*	*Date*	*Comments*	*Pt. Initials*	*Dr. Initials*

Gentle Dental Family Dentistry Inc.

Dental History

Do your gums bleed? ___________

Are your teeth sensitive to any of the following? (Circle all that apply):

Hot - Cold - Sweets - Sour - Pressure

Please indicate which areas: R L

Do you have any sores or lumps in/near your mouth? _________________

Have you had any head or neck injuries? ______When: _____/_____/_____

Do you have any jaw problems such as *Clicking* or *Popping*? ___________

Clicking: _______Where? _________________________________

Popping: _______Where? _________________________________

Would you like to whiten your teeth? ____________

Interested in a Snore Guard ___________

Interested in "Six Month Smiles –clear braces" ____________

Any fear of the dentist or previous bad experience? ____________________

Difficulty opening or closing jaw? _________

Chewing? ____________________

Orthodontic Work? _____________

Clenching Teeth? ______________

Grinding Teeth? _______________

Have you ever had difficult extractions in the past? ________

Prolonged Bleeding? ________

Getting Anesthetized? _______

Dry Socket? ________

Have you had proper instruction on:

Brushing? ________

Flossing? _________

Do you use a WaterPik/Flosser? ______ **Mechanical toothbrush?**______

Last cleaning and exam: 3 mo____ /6 mo___/ 1 yr____ /2 yr___/longer___

Please describe the main reason for visiting today. Please include overall goals, concerns and esthetic desires: _________________________________

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing inaccurate information can be dangerous to my health. I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dental Group insurance benefits otherwise payable to me.

I understand that my Dental Insurance Carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on myself or my dependents, including Collection fees, Court costs and Attorney fees.

X____ **Date**_______/_______/__________

Signature of Patient or (Parent/Guardian if Minor)

----Office Use Only Below This Line----

Doctor's Comments

#	X-rays	Date
_____	BWX's	___/____/____
_____	Panx	___/____/____
_____	PA's	___/____/____

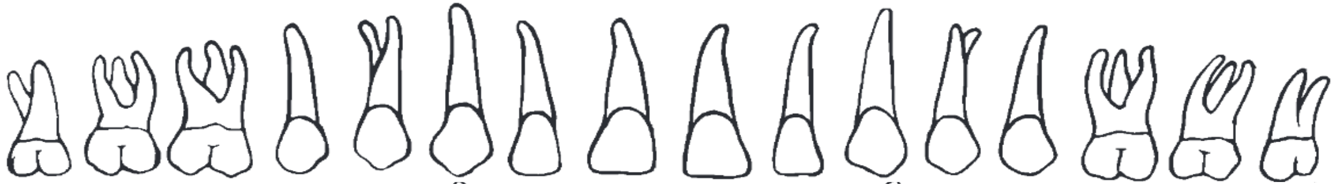
Sent in: __/___/_____

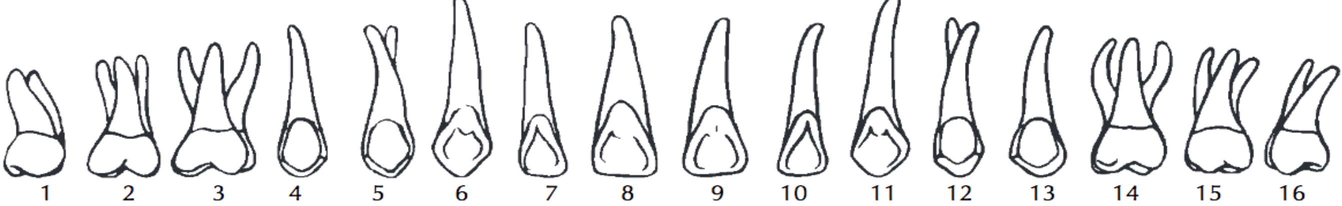
Doctor's Signature: ____________________________________ **Date**_______/_______/__________

Date		

Name: ______________________________ Medical Alerts: __________________________ Patient ID #: ___________

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Date
Facial																	5.
																	4.
																	3.
																	2.
																	1.





Lingual																	1.
																	2.
																	3.
																	4.
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																	Date
Lingual																	5.
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																	3.
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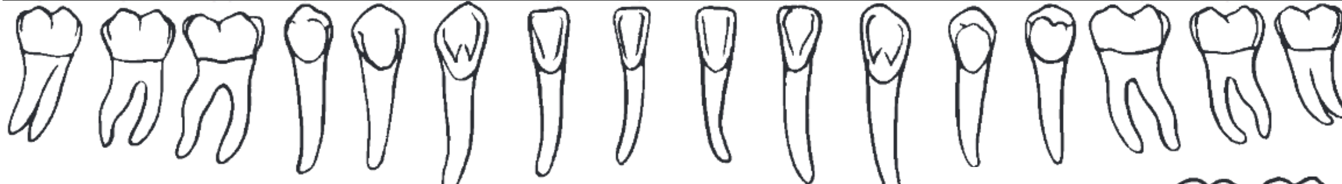
																	1.
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	



	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Date
Facial																	1.
																	2.
																	3.
																	4.
																	5.

Significant periodontal findings or recommendations:

1. Date: ____________

2. Date: ____________

3. Date: ____________

4. Date: ____________