

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 _____

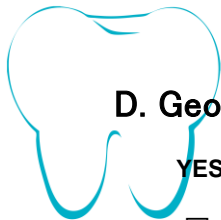
DENTAL HISTORY

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

MEDICAL HISTORY

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

- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you or have you ever been told that you have | | |
| 2. Has there been any change in your general health | | | a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| within the past year? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you have a cardiac pacemaker? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. My last physical examination was on _____ | | | 14. Do you have or have you had any of the following | | |
| 4. Are you under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | illnesses or problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. The name and address of my physician is: _____ | | | a. Damaged heart valves or artificial heart | | |
| _____ | | | valves?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any serious illness or operation? | <input type="checkbox"/> | <input type="checkbox"/> | b. Congenital heart lesions?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you been hospitalized or had a serious illness | | | c. Cardiovascular disease ? (Heart trouble, | <input type="checkbox"/> | <input type="checkbox"/> |
| within the past five years ?..... | <input type="checkbox"/> | <input type="checkbox"/> | heart attack, high blood pressure, arteriosclerosis, | | |
| If yes to question 6 and/or 7, explain: _____ | | | embolism, coronary insufficiency/occlusion) | | |
| _____ | | | d. Rheumatic fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have chest pain upon exertion? | <input type="checkbox"/> | <input type="checkbox"/> | e. Allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you ever short of breath after mild exercise? | <input type="checkbox"/> | <input type="checkbox"/> | f. Sinusitis?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do your ankles swell? | <input type="checkbox"/> | <input type="checkbox"/> | g. Asthma or hay fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you get short of breath when you lie down or | | | h. Hives or skin rashes? | <input type="checkbox"/> | <input type="checkbox"/> |
| require additional pillows when you sleep? | <input type="checkbox"/> | <input type="checkbox"/> | i. Fainting spells or seizures? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | j. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |



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

YES NO

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

* If yes, please explain: _____

15. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? YES NO

16. Do you bruise easily? YES NO

17. Have you ever required a blood transfusion? YES NO
If yes, explain the circumstances _____

18. Do you have any blood disorder such as anemia? YES NO

19. Have you had surgery or X-ray treatment for a tumor, growth or condition to your head or neck? YES NO

20. Are you employed in any situation which exposes you regularly to X-rays or other ionizing radiation?... YES NO

21. Are you wearing contact lenses?..... YES NO

22. Do you smoke? YES NO

YES NO

23. Are you allergic or have you reacted adversely to:

- a. Local anesthetics?..... YES NO
- b. Penicillin or other antibiotics?..... YES NO
- c. Sulfa drugs? YES NO
- d. Barbiturates, sedatives or sleeping pills? ... YES NO
- e. Aspirin? YES NO
- f. Iodine? YES NO
- g. Codeine or other narcotics? YES NO
- h. Other? YES NO

24. Are you taking any of the following?

- a. Antibiotics o sulfa drugs?..... YES NO
- b. Anticoagulants (blood thinners)? YES NO
- c. Medicine for high blood pressure? YES NO
- d. Cortisone or steroids? YES NO
- e. Tranquilizers?..... YES NO
- f. Antihistamines?..... YES NO
- g. Aspirin? YES NO
- h. Insulin, similar drug? YES NO
- i. Digitalis or drugs for heart problems?..... YES NO
- j. Nitroglycerin? YES NO
- k. Oral contraceptives or hormonal therapy?... YES NO
- l. Medicine for Osteoporosis like Boniva, Actonel, Fosamax, Zometa, Aredia?..... YES NO
- H. Other: _____

WOMEN

25. Are you pregnant or could be pregnant?..... YES NO

26. Last menstrual period _____

27. Do you have any problems with associated with your menstrual period? YES NO

28. Are you nursing? YES NO

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.

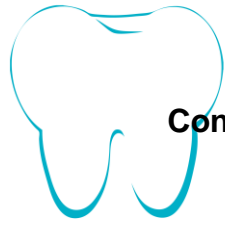
Signature of patient

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 indicated 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

