COOPER DENTAL GROUP
ORMOND BEACH

Quality Smiles,
Compassionate Care

Name: Dr/Mr./Mrs./Miss/Ms.: _____ MI: _____ Sex: M/F DOB: _____
Address: _____ SS#: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Patient Email (or Guardian): _____
Responsible Party: _____ SS#: _____DOB: _____
Spouse: Mr./Mrs.: _____ SS#: _____DOB: _____
How did you hear about our office? _____ (New patients only)
Emergency Contact (Name): _____ Relation: _____ Phone #_____

Dental Insurance Information

Dental Insurance Company: _____ Phone: _____
Name of Insured: _____ Relationship to patient: _____
Insurance ID#: _____ Insurance Group#: _____

Medical History Information

Former Dentist: _____Phone#_____ Date last seen: _____

Primary Care Physician's Name: _____ Phone# _____ Date last seen: _____

Are you currently under medical treatment now? YES / NO If yes, please explain: _____

Do you use tobacco? YES/ NO / PAST USE Do you take blood thinners? YES/ NO Do you take daily aspirin? YES/ NO

Do you take (or have you taken) bone-strengthening medications? YES / NO |If you answered YES, taken via IV or pills (circle one)

Have you taken any medications for prostate conditions? YES/NO | If YES, via IV or pills (circle one) Drug name _____

Are you diabetic? YES/ NO | If Yes, Type I or Type II (circle one), and what was your last HbA1c _____ test date_____

Have you had a heart attack, TIA, or stroke? YES/NO | If Yes, Cardiologist/Neurologist Name_____date_____

Are you taking opioids, barbiturates, or pain medications? YES/NO | Have you experienced drug/alcohol addiction? YES/NO

Have you taken steroids in the past year? YES/NO | If Yes, medication_____dose_____ frequency_____ duration_____

Do you use any recreational drugs or alcohol? YES/NO (this is confidential) Please describe: _____

_____

Please indicate here if an attachment with additional drug information is appended: YES / NO

Is there any other medical or dental history or other information we should know about? (Please describe):

_____

PLEASE COMPLETE THE BACK SIDE OF FORM Patient Initials: _____ Today's Date: _____

What are your goals for your dental treatment, and what is your chief concern currently? How can we make you smile?

_____

_____

_____

_____

Do you have dental anxiety? NO / MILD / MODERATE / SEVERE | Do you have GERD/Acid Reflux? YES/NO Dry Mouth? YES / NO

Past medical history			
Do you now or have you ever had:			
❑ Diabetes	❑ A-Fib	❑ Emphysema/COPD	❑ Jaundice
❑ High blood pressure	❑ Heart murmur	❑ Gout	❑ Hepatitis
❑ High cholesterol	❑ Infective Endocarditis	❑ Sjogrens Syndrome	❑ Liver Impairment
❑ Hypo ❑ Hyer -thyroidism	❑ Congenital heart	❑ TMJ Joint Pain	❑ Stomach or peptic ulcer
❑ Bleeding Disorder	defect prosthetic, or graft	❑ Arthritis	❑ Rheumatic fever
❑ Cancer (type)	❑ Pneumonia	❑ Cataracts	❑ Tuberculosis
_____	❑ Pulmonary embolism	❑ Kidney disease	❑ HIV/AIDS
❑ Head/Neck Radiation Therapy	❑ Asthma	❑ Lupus	❑ Herpes / Cold Sores
❑ Leukemia	❑ Alzeheimers/Dimentia	❑ Sinus Trouble	❑ Currently Pregnant
❑ Psoriasis	❑ Parkinsons	❑ Kidney stones	❑ Fibromyalgia
❑ Angina	❑ Epilepsy (seizures)	❑ Crohn's disease	❑ Anemia
❑ Heart Attack (MI)	❑ Stroke	❑ Colitis	❑ Depression/Anxiety
Other medical conditions (please list):			

Allergies

ALLERGIC TO: NONE

Seasonal
Any Metals
Barbiturates
Opioids/Codeine
Iodine
Latex Rubber
Anesthetics/Novocain
Penicillin/Antibiotics
Sulfa Drugs
Acrylic
Other: _____

Please describe your reaction to any items you marked as allergies:

_____

_____

Have you ever had head and neck cancer or radiation? YES / NO If yes, please explain. _____

CURRENT MEDICATIONS			
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:			
Name of drug	**Reason you take drug**	**Dose/Frequency**	**Duration**
1.			
2.			
3.			
4.			
5.			
6.			

Authorization and Release

I hereby consent to treatment as necessary or desirable to the care of the patients named above, including but not restricted to whatever drugs, medicine, performance of medical/dental procedures, x-rays, or other studies that the doctor orders. It is essential to the performance of good dentistry that the dentist has a full understanding of the physical well-being of the patient. Your cooperation in submitting this information is greatly appreciated and will enable us to serve your particular needs safely and with greater satisfaction. All information is confidential. I also acknowledge full responsibility for the payment of services and agree to pay for them in full at the time of service unless other arrangements have been made. 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 authorize and request my insurance to pay directly to the dentist or dental group benefits otherwise payable to me. I understand that my dental pays less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or responsible party if patient is under age 18:) X_____Date:_____

Name of Signer (print) _____ Relationship SELF / PARENT-GUARDIAN / POA _____