University Dental Group
1430 South Dixie Highway, Suite 312, Coral Gables, FL 33146

PATIENT INFORMATION

Dr., Mr., Mrs., Ms., Miss(Circle One) Today's Date_____

Name(First, Middle, Last)_____ Date of Birth_____

Telephone #( )_____ Cell Phone #( )_____ Business #( )_____

Address_____ City/State_____Zip Code_____

Marital Status_____SS #_____Occupation_____E-mail Address_____

How Would You Prefer Us to Contact You? _____Home Phone _____Business _____Cell Phone _____E-mail _____Text Messaging

Name of Spouse_____Occupation_____Contact #( )_____

Other Emergency Contact_____ #( )_____

Previous Dentist_____Date of Last Visit?_____

Name of Physician_____Contact #( )_____

Who can we thank for referring you to this office?_____

How can we be of service to you?_____

Dental Insurance Information

Name of Insurance Carrier_____Telephone #_____

Address of Insurance Carrier_____City/State_____Zip Code_____

Name of Insured Party_____Relation_____Date of Birth_____

Social Security #_____Employer of Insured Party_____Policy #_____

Have you have ever been diagnosed with or suffered from any of the following?

☐ Frequent or Severe Headaches	☐ Allergies or Hives	☐ Frequent Bruises	☐ Stroke	☐ Breast Cancer
☐ Immunocompromise	☐ Thyroid Disease	☐ HIV/AIDS	☐ Swollen Ankles	☐ Fatigue
☐ Shortness of Breath	☐ Liver Disorders	☐ Recent Loss of Weight	☐ Blood Disorders	☐ Epilepsy/Seizures
☐ High or Low Blood Pressure	☐ Hepatitis	☐ Kidney Disorders	☐ Anemia	☐ Cancer
☐ Diabetes Type: ☐I or ☐II	☐ Hypoglycemia	☐ Bone Disorders	☐ Leukemia	☐ Chemotherapy
☐ Arthritis or Rheumatism	☐ Lip Sores/Blisters	☐ Skin Disorders	☐ Prolonged Bleeding	☐ Radiation Treatment
☐ Drug Dependence	☐ Dizziness or Fainting	☐ Psychiatric Problems	☐ Blood Transfusion	☐ Stomach Ulcers
☐ Alcohol Dependence	☐ Venereal Disease	☐ Glaucoma	☐ Hemophilia	☐ Nervousness
☐ Tuberculosis	☐ Emphysema	☐ Asthma	☐ Rheumatic Fever	☐ Sinus Trouble
☐ Congenital Heart Defect	☐ Heart Murmur	☐ Heart Valve Prolapse	☐ Heart Attack	☐ Chest Pains

Do You or Have You Had Any of the Following?

☐ Pacemaker ☐ Prosthetic Heart Valve(s) ☐ Cardiac Arrest ☐ Heart Surgery

over, please

☐Congestive Heart Failure ☐Hypertension ☐ Artificial Joint(s)

To avoid any problems associated with rheumatic fever, heart disease or murmur, artificial valves or joints, it may be necessary for you to take antibiotics before each dental visit. Please consult with your physician or cardiologist if you have any questions in reference to this premedication.

☐ Any Other Condition or Ailment? Specify:_____

1. Please List any Prescription Medications You Are Taking:_____
_____

2. Please List any Non-Prescription Medications or Supplements You Are Taking:_____
_____

3. Are you **allergic** to any of the following?

☐ Local Anesthesia ☐ Aspirin ☐ Sulfa Drugs ☐ Codeine ☐ Iodine
☐ Penicillin ☐ Erythromycin ☐ Other Antibiotics ☐ Latex ☐ Barbiturates, Sedatives, Sleeping Pills
☐ Other_____ If you have answered yes to allergies, please explain:_____

4. Do you use alcohol with any regularity? Yes No How much?_____
5. Do you use tobacco products (smoking, chewing, dipping)? Yes No How much?_____
6. Do you use recreational drugs? Yes No_____
7. Last physical exam:_____
8. Please list any hospitalizations:_____
_____

Women Only:

☐ Are you or is it possible that you are pregnant? ☐ Are you Nursing? ☐ Taking oral contraceptives?_____
☐ Have you reached menopause? ☐ Are you taking any replacement hormones?_____ _____
☐ Have you ever taken a bisphosphonate medication for osteoporosis such as Fosamax, Didronel, Reclast, Boniva, Actonel?

Please mark the appropriate box if the following dentally related questions apply to you?

☐ You usually take antibiotics before your dental visits.
☐ You have had pain in your jaw joint or facial muscles.
☐ Your jaw has ever stayed open or closed.
☐ Your jaw makes any noise when you open your mouth.
☐ You have lost feeling in your face or other part of your body.
☐ Your teeth are sensitive to ☐ heat, ☐ cold, ☐ sweets.
☐ You have had any problems associated with dental treatment.
☐ You wear a removable appliance like a denture or retainer etc.
☐ You engage in a sport that may subject your dentition to injury.
☐ You have had any trauma to the face or jaw.
☐ You suffer from dry mouth frequently.
☐ You are happy with the appearance of your teeth
☐ You have had periodontal treatment? If yes, when?_____ By whom?_____
☐ You have had orthodontic treatment? If yes, when?_____ By whom?_____
☐ You have had an upsetting experience or there is something thing that bothers you about dental treatment._____

By signing below you authorize Dr. Richard D. Morales and Dr. Rebeca M. Garcia and their staff to do everything necessary and appropriate to make a complete diagnosis of you, the dental patient, and your oro-facial needs. This may include radiographs, models, photographs, medication, and the use of local anesthesia. I understand that any photographs and models may be used for medico-dental education purposes. I also understand that I am responsible for payment of any services that I or any of my dependents may receive and that such payment is expected as these services are rendered unless prior arrangements are made. In addition I authorize the forwarding of any necessary information to my insurance carrier and/or any specialists to whom I may be referred as the need may arise.

Signed:_____Date:_____

over, please