MY ISLAND DENTAL
Merritt Island

321-631-2111
myislanddental.com

WE ARE PLEASED TO WELCOME YOU TO OUR PRACTICE.
Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Please Email Completed Forms to: concierge@myislanddental.com

PATIENT INFORMATION

Name ______________________________ Soc. Sec. # ______________
Last Name *First Name* *Middle Initial*

Address ______________________________

City ______________ State ____ Zip ________ Home Phone ______________

Cell Phone ______________ Email ______________________________

Sex ☐ **M** ☐ **F** Age ____ Birthdate __________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employer ______________________ Occupation ______________

Work Address ______________________________

Work Phone ______________ Work Email ______________________________

Notify in case of emergency ______________________ Cell Phone ______________

Work Phone ______________ Email ______________________________

PRIMARY INSURANCE

Person Responsible for Account ______________________________
Last Name *First Name* *Middle Initial*

Relation to Patient ______________________ Birthdate __________ Soc. Sec. # ______________

Address *(if different from patient)* ______________________________

City ______________ State ____ Zip ________ Home Phone ______________

Cell Phone ______________ Email ______________________________

Person Responsible Employed by ______________________ Occupation ______________

Work Address ______________________________

Work Phone ______________ Work Email ______________________________

Insurance Company ______________________ Phone ______________

Contract # ______________ Group # ______________ Subscriber's # ______________

Name(s) of other dependents under this plan ______________________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No Subscriber's Name ______

Relation to Patient ______ Birthdate ______ Soc. Sec. # ______

Address *(if different from patient)* ______

City ______ State ______ Zip ______ Home Phone ______

Cell Phone ______ Email ______

Subscriber Employed by ______

Work Phone ______ Work Email ______

Insurance Company ______ Phone ______

Contract # ______ Group # ______ Subscriber's # ______

Name(s) of other dependents under this plan ______

DENTAL HISTORY

What would you like us to do today? ______

Are you in dental discomfort today? ______

Former Dentist ______ Dentist Phone ______

Dentist Address ______

Date of last dental care ______ Date of last X-rays ______

Check **Y for yes** or **N for no** if you have or have not had the following:

☐ **Y** ☐ **N** Bad Breath

☐ **Y** ☐ **N** Sensitivity to cold

☐ **Y** ☐ **N** Sensitivity to cold

☐ **Y** ☐ **N** Loose or Broken teeth

☐ **Y** ☐ **N** Food collection between teeth

☐ **Y** ☐ **N** Bleeding gums

☐ **Y** ☐ **N** Sensitivity when biting

☐ **Y** ☐ **N** Sensitivity to hot

☐ **Y** ☐ **N** Periodontal treatment

☐ **Y** ☐ **N** Grinding or clenching teeth

☐ **Y** ☐ **N** Clicking or popping jaw

☐ **Y** ☐ **N** Sores or growths in mouth

How often to you brush? ______ How often to you floss? ______

How do you feel about the appearance of your teeth? ______

Have you ever experienced an adverse reaction during or in conjunction with a medial or dental procedure? ☐ **Y** ☐ **N**

MEDICAL HISTORY

Physician's name ______ Phone ______

Address ______ Physician's Email ______

Date of last visit ______

Have you had any serious illnesses or operations? ☐ **Y** ☐ **N** If yes, describe ______

Are you currently under physician care? ☐ **Y** ☐ **N** If yes, describe ______

Have you ever had a blood transfusion? ☐ **Y** ☐ **N** If yes, give approximate date(s) ______

Have you ever taken Fen-when/Redux? ☐ **Y** ☐ **N**

Women: Are you pregnant? ☐ **Y** ☐ **N** Taking birth control pills? ☐ **Y** ☐ **N**

MEDICAL HISTORY CONTINUED

Check **Y for yes** or **N for no** if you have or have not had the following:

- ☐ **Y** ☐ **N** AIDS/HIV Positive
- ☐ **Y** ☐ **N** Anaphylaxis
- ☐ **Y** ☐ **N** Anemia
- ☐ **Y** ☐ **N** Arthritis, Rheumatism
- ☐ **Y** ☐ **N** Artificial heart valves
- ☐ **Y** ☐ **N** Artificial joints
- ☐ **Y** ☐ **N** Asthma
- ☐ **Y** ☐ **N** Atopic (allergy prone)
- ☐ **Y** ☐ **N** Blood disease
- ☐ **Y** ☐ **N** Cancer
- ☐ **Y** ☐ **N** Chemical dependency
- ☐ **Y** ☐ **N** Chemotherapy
- ☐ **Y** ☐ **N** Circulatory problems
- ☐ **Y** ☐ **N** Cortisone treatments
- ☐ **Y** ☐ **N** Cough up blood
- ☐ **Y** ☐ **N** Cough, persistent
- ☐ **Y** ☐ **N** Diabetes
- ☐ **Y** ☐ **N** Epilepsy
- ☐ **Y** ☐ **N** Fainting
- ☐ **Y** ☐ **N** Food allergies
- ☐ **Y** ☐ **N** Glaucoma
- ☐ **Y** ☐ **N** Headaches
- ☐ **Y** ☐ **N** Heart problems

Describe ______________________

____

- ☐ **Y** ☐ **N** Hemophilia/ Abnormal bleeding
- ☐ **Y** ☐ **N** Hepatitis
- ☐ **Y** ☐ **N** Herpes
- ☐ **Y** ☐ **N** High blood pressure
- ☐ **Y** ☐ **N** Jaw pain
- ☐ **Y** ☐ **N** Kidney disease *or* malfunction
- ☐ **Y** ☐ **N** Liver disease
- ☐ **Y** ☐ **N** Material allergies *(latex, wool, metal, chemicals)*
- ☐ **Y** ☐ **N** Mitral valve prolapse
- ☐ **Y** ☐ **N** Nervous problems
- ☐ **Y** ☐ **N** Psychiatric care
- ☐ **Y** ☐ **N** Radiation treatment
- ☐ **Y** ☐ **N** Rapid weight gain or loss
- ☐ **Y** ☐ **N** Respiratory disease
- ☐ **Y** ☐ **N** Rheumatic fever
- ☐ **Y** ☐ **N** Scarlet fever
- ☐ **Y** ☐ **N** Shingles
- ☐ **Y** ☐ **N** Shortness of breath
- ☐ **Y** ☐ **N** Skin rash
- ☐ **Y** ☐ **N** Spina Bifida
- ☐ **Y** ☐ **N** Stroke
- ☐ **Y** ☐ **N** Surgical implant
- ☐ **Y** ☐ **N** Swelling of feet or ankles
- ☐ **Y** ☐ **N** Thyroid disease *or* malfunction
- ☐ **Y** ☐ **N** Tobacco habit
- ☐ **Y** ☐ **N** Tonsillitis
- ☐ **Y** ☐ **N** Tuberculosis
- ☐ **Y** ☐ **N** Ulcer/Colitis
- ☐ **Y** ☐ **N** Venereal disease

MEDS

List medications you are currently taking, if any:

____

____

List drug allergies, if any:

____

____

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charters whether or not paid by insurance.

Signature ______________________ Date ______________

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENT HAVE BEEN APPROVED.

ADDITIONAL MEDICAL HISTORY:

1. Are you currently and/or have taken any of the following medication for Osteoporosis or cancer therapy? Or any others not listed?

Boniva* Fosamax* Aredia* Zometa* Didronel*

☐ **YES** ☐ **NO**

2. Do you have any history of substance abuse? If yes, please describe?

☐ **YES** ☐ **NO**

Comments: ____

____

3. Do you have any other disease, condition, or problem not listed?

☐ **YES** ☐ **NO**

Explain____

____

How did you hear about us?

Friends/family ______________ Who?____________________

Internet *(Check All That Apply)* ☐ Google, ☐ Bing, ☐ Yahoo, ☐ Other

☐Yellow Pages ☐Walk-in ☐Other ____________________

Patient's Signature ______________________________ Date ______________

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