AVENTURA DENTAL GROUP

20475 BISCAYNE BOULEVARD • AVENTURA, FLORIDA 33180
(305) 935-4030 • FAX: (305) 935-4448

Patient _____ Birth Date _____ Age _____

☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ WIDOWED ☐ DIVORCE S.S.# _____ Sex _____

Home Address _____ City _____ Zip _____

Home Phone _____ Pager _____ Cellular _____

Patient or Responsible Parent Employed By _____

Business Address _____ City _____

Occupation _____ Business Phone _____

Name of Spouse _____ Occupation _____

Business Address _____ City _____

Spouse Employed By _____ Business Phone _____

Referred By _____ Do you have insurance? _____

Dentist _____ Physician _____

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. When was your last physical examination? _____
3. Are you under the care of a physician? ..... Yes No
   If yes, condition _____
4. Have you been hospitalized or had a serious illness within the last 5 years? ..... Yes No
   If yes, what? _____
5. Circle any of the following which you have or have had:

Rheumatic Fever	Arthritis or Rheumatism	Allergies
Asthma or Hay Fever	Heart Murmur	Glaucoma
Fainting spells or seizures	Heart Trouble	Lung Disease
Tuberculosis	Kidney Problems	Thyroid Disease
Diabetes	High/Low Blood Pressure	Venereal Disease
Hepatitis, Jaundice or Liver Disease	Stroke	AIDS / HIV Positive

6. Do you have any blood disorders such as anemia? ..... Yes No
7. Have you ever had any unusual reaction to an anesthetic or drug? (i.e.: penicillin, codeine or aspirin) .. Yes No
   If so, what drugs or medications? _____
8. Are you taking any medications now? Is so, what? _____
9. Do you have any history of prolonged bleeding following an operation or accident? ..... Yes No
   If yes, describe _____
10. Have you had any x-ray treatment for tumor, growth or other condition? ..... Yes No
    If yes, describe _____
11. Do you wear contact lens? ..... Yes No
12. Have you taken any cortisone or steroids during the past year? ..... Yes No
13. Do you have any signs today of a cold or sinus condition? ..... Yes No
14. Are you pregnant (women) if so, how many months? _____ Yes No
15. How many hours has it been since you had anything to eat or drink? _____
16. Do you have any disease, condition, or problem not listed above that I should know? If so, explain _____

_____

_____

Please sign and date other side