Derrick Dental Care

Anthony C. Derrick DDS
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Longwood, Fl 32779
407-788-8400

Patient Information

Name: Home Phone Cell phone
Last--First--

Spouse: Business Phone
Last--First--

Address: City: State: Zip:

Street____

Date of Birth ---------------------------- Age --------------Sex: M F Married ☐ Single ☐ Widowed ☐ Divorced ☐
Social Security No.--E-Mail Address---
Occupation---Employer--

Emergency contact:
Name---Relationship-----------------------------------Phone Number-----------------------------
Whom may we thank for referring you? --

Dental Insurance

Who is responsible for account_________________________________Relationship to patient_________________________________
Insurance co.____
Group #______________________Plan #______________________________Phone Number______________________________
Insurance Co. Address____
Subscribers Name____
Subscribers Date of Birth______________________Social security number___________________________relationship to patient____________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I have insurance coverage and assign directlyto Dr. Derrick all insurance benefits, if any , otherwise payable to me for services rendered. I understand that I am financiall responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions.

____
Responsible party signature Date

Dental History

Reason for today's visit_______________
____
Former Dentist____________________
City/State________________________
Date of last dental visit______________
Date of last dental x-rays_____________
Place circle"yes" or "no" to indicate if you have had any of the following.

Bad breath Yes No
Bleeding gums Yes No
Blisters on lips or mouth Yes No
Burning sensation on tongue Yes No
Chew on side of mouth Yes No
Cigarette, pipe, or cigar smoking Yes No
Clicking or popping jaw Yes No
Dry mouth Yes No
Fingernail biting Yes No
Food collection between the teeth Yes No
Foreign objects Yes No
Grinding teeth Yes No
Gums swollen or tender Yes No
Jaw pain or tiredness Yes No
Lip or check biting Yes No
Loose teeth or broken Fillings Yes No
Mouth breathing Yes No
Mouth pain, brushing Yes No
Orthodontic treatment Yes No
Pain around ear Yes No
Periodontal treatment Yes No
Sensitivity to cold Yes No
Sensitivity to heat Yes No
Sensitivity to sweets Yes No
Sensitivity to biting Yes No
Sores or growths in your mouth Yes No

How often do you floss__________
How often do you brush_________

Health History

AIDS/HIV	Yes	No	Emphysema	Yes	No	Radiation Treatment	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Respiratory disease	Yes	No
Arthritis, Rheumatism	Yes	No	Fainting or dizziness	Yes	No	Rheumatic Fever	Yes	No
Atrificial Heart Valves	Yes	No	Glaucoma	Yes	No	Scarlet Fever	Yes	No
Artificial Joints	Yes	No	Headaches	Yes	No	Shortness of Breath	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Back Problems	Yes	No	Heart problems	Yes	No	Skin Rash	Yes	No
Bleeding abnormally,			Hepatitis type______	Yes	No	Special Diet	Yes	No
with surgery	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Blood Disease	Yes	No	High Blood Pressure	Yes	No	Swollen feet or ankles	Yes	No
Cancer	Yes	No	Jaundice	Yes	No	Thyroid Problems	Yes	No
Chemical Dependency	Yes	No	Jaw Pain	Yes	No	Tonsillitis	Yes	No
Chemotherapy	Yes	No	Kidney Disease	Yes	No	Tuberculosis	Yes	No
Circulatory Problems	Yes	No	Liver Disease	Yes	No	Tumor or growth on		
Congenital Heart			Low Blood Pressure	Yes	No	Head or neck	Yes	No
Lesions	Yes	No	Mitral Valve Prolapse	Yes	No	Ulcer	Yes	No
Cortisone treatments	Yes	No	Nervous Problems	Yes	No	Venereal Disease	Yes	No
Cough, persistent or			Pacemaker	Yes	No	Weight Loss		
bloody	Yes	No	Psychiatric Care	Yes	No	Unexplained	Yes	No
Diabetes	Yes	No	Women:					
Do you wear contacts	Yes	No	Are you Pregnant	Yes	No	Due date______________________		
			Taking birth control pills	Yes	No	Are you nursing	Yes	No

Medications

List any medications you are currently taking and the correlating diagnosis.

Medications Reason

____

____

Allergies

Please mark any medications that you are allergic to.

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other______________

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____

____

Smile Information

If you could change one thing about your front teeth, what would it be? ____

How do you feel about the color of your teeth? ____

If there was anything you could change about your back teeth what would it be? ____

Do you like the way they are shaped? ☐ Yes ☐ No

Are your front teeth as straight as you would like them? ☐ Yes ☐ No

Do you have difficulty chewing? ☐ Yes ☐ No

Do you get food trapped between your teeth? ☐ Yes ☐ No

Do you have sensitivity to hot, cold or sweets? ☐ Yes ☐ No

Are you satisfied with their overall appearance? ☐ Yes ☐ No

Are you missing any teeth? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No