This information is necessary for our files only and will be confidential

Name ____ Birthdate _____/_____/_____
Last First Middle

If Minor, Guardian's Name ______________________________ Relationship ______________

Address______________________________ City ________________ State_______ Zip________

Patient [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ] Minor [ ] Male [ ] Female

Home # (_____) ______________ Cell # (_____) ______________ Work # (_____) ______________

Driver's Lic. #____________________ State _________ SS #______________________

Email Address______________________________

Employer______________________________ Occupation______________________________

Spouse/SO Name ______________________________ Cell # (_____) ______________

Emergency Contact______________________________ Cell # (_____)______________
Name Relationship to Patient

Whom may we thank for your referral? ______________________________

Dental Insurance Information:

Primary Dental Insurance Company ____________________ Phone # (_____)______________

Primary Subscriber Name ____________________ Relationship__________ DOB ___/___/___

Dependent Name ____________________ Relationship__________ DOB ___/___/___

Subscriber ID #______________________________ Group # ____________________

Cancellations: When you schedule an appointment with our practice, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Effective April 1, 2021 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least a **24 Hour notice** will be considered a No Show and charged a **$50.00 Fee.**

Phone/Text/Email Confirmation: It is our office policy that we call to confirm your appointment. It is also our policy that you call 24 hours prior to your appointment to cancel your appointments. We may also call you regarding medical & financial issues. May we contact you by: **Call:** Y / N **Text:** Y / N **Email:** Y / N Allow Voicemails: Y / N

Consent for Treatment and Payment

The above information is complete and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated. I agree that regardless of insurance coverage, I am responsible or payment of services rendered.

______________________________ _____/_____/_____
Patient Signature Date

DELICATE DENTISTRY
of Palm Harbor

OFFICE POLICIES OF LUISA RODRIGUEZ D.D.S

1. It is our office policy that we will address you by your first or last name.
2. ***Verbal Authorization***: It is our office policy to get verbal authorization from all new patients to confirm appointments and leave messages. Also patients must call/text/email us 24 hours in advance to cancel any appointments.
3. ***Photo & Video Examinations***: It is our office policy to take photos/videos of your face, mouth, and teeth which is stored in your chart. We may take the photography or it may be taken by a designee approved by my healthcare provider. The photography shall be used for medical records and if, in the judgement of my healthcare provider, medical research, education or science will be benefited by its use, such photography and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he/she may deem proper in the interest of medical education, knowledge and research. It is specifically understood that in any such publication or use, all reasonable effort will be made so that I shall not be identified by name. I understand I may be recognized and identifiable in the photography. All reasonable efforts will be made to avoid personal identification.
4. It is our office policy to share Protected Health Information with labs, consulting dentists, physicals and hospitals. We will also contact the pharmacy of your choice. We will only exchange minimum necessary Protected Health Information for each transaction.
5. Our office is HIPPA compliant and the staff has been trained in the HIPPA Privacy Act. We will do everything we can to protect your Patient Health Information. However, our office was designed before the HIPPA law so please be respectful of other patient's privacy.

I, agree to all of the above office policies of Luisa Rodriguez D.D.S and give my authorization to all of the above. I, authorize Luisa Rodriguez D.D.S to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Luisa Rodriguez D.D.S. I authorize Luisa Rodriguez D.D.S to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all the rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray, consulting physicians and hospitals. We will contact the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

____ ________/__________/_________

Patient Responsible Party Signature *Date*

DELICATE DENTISTRY
of Palm Harbor

MEDICAL HISTORY

Patient Name ______ Nickname ______ Age ______

Name of Physician/and their specialty ______

Most recent physical examination ______ Purpose ______

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD: (YES / NO)

1. hospitalization for illness or injury ______ ☐ ☐
2. an allergic or bad reaction to any of the following: ☐ ☐
   - ○ aspirin, ibuprofen, acetaminophen, codeine ______
   - ○ penicillin ______
   - ○ erythromycin ______
   - ○ tetracycline ______
   - ○ sulfa ______
   - ○ local anesthetic ______
   - ○ fluoride ______
   - ○ chlorhexidine (CHX) ______
   - ○ Iodine ______
   - ○ metals (nickel, gold, silver, ______)
   - ○ latex ______
   - ○ nuts ______
   - ○ fruit ______
   - ○ milk ______
   - ○ red dye ______
   - ○ other ______
3. heart problems, or cardiac stent within the last six months ______ ☐ ☐
4. history of infective endocarditis ______ ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) ______ ☐ ☐
6. pacemaker or implantable defibrillator ______ ☐ ☐
7. orthopedic or soft tissue implant (e.g., joint replacement, breast implant) ______ ☐ ☐
8. heart murmur, rheumatic or scarlet fever ______ ☐ ☐
9. high or low blood pressure ______ ☐ ☐
10. a stroke (taking blood thinners) ______ ☐ ☐
11. anemia or other blood disorder ______ ☐ ☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) ______ ☐ ☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ______ ☐ ☐
14. chronic ear infections, tuberculosis, measles, chicken pox ______ ☐ ☐
15. breathing problems (e.g., asthma, stuffy nose, sinus congestion) ______ ☐ ☐
16. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) ______ ☐ ☐
17. kidney disease ______ ☐ ☐
18. liver disease or jaundice ______ ☐ ☐
19. vertigo (e.g., "the room is spinning") ______ ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency ______ ☐ ☐
21. hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) ______ ☐ ☐
22. high cholesterol or taking statin drugs ______ ☐ ☐
23. diabetes (HbA1c = ______) ______ ☐ ☐
24. stomach or duodenal ulcer ______ ☐ ☐
25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) ______ ☐ ☐
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) ______ ☐ ☐
27. arthritis or gout ______ ☐ ☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) ______ ☐ ☐
29. glaucoma ______ ☐ ☐
30. contact lenses ______ ☐ ☐
31. head or neck injuries ______ ☐ ☐
32. epilepsy, convulsions (seizures) ______ ☐ ☐
33. neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease) ______ ☐ ☐
34. viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) ______ ☐ ☐
35. any lumps or swelling in the mouth ______ ☐ ☐
36. hives, skin rash, hay fever ______ ☐ ☐
37. STI/STD/HPV ______ ☐ ☐
38. hepatitis (type ____) ______ ☐ ☐
39. HIV/AIDS ______ ☐ ☐
40. tumor, abnormal growth ______ ☐ ☐
41. radiation therapy ______ ☐ ☐
42. chemotherapy, immunosuppressive medication ______ ☐ ☐
43. difficulties with stress management ______ ☐ ☐
44. psychiatric treatment, antidepressants, mood stabilizing medications ☐ ☐
45. concentration problems or ADD/ADHD ______ ☐ ☐
46. alcohol/recreational drug use ______ ☐ ☐

ARE YOU: (YES / NO)

47. presently being treated for any other illness ______ ☐ ☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) ______ ☐ ☐
49. taking medication for weight management ______ ☐ ☐
50. taking dietary supplements, vitamins, and/or probiotics ______ ☐ ☐
51. often exhausted or fatigued ______ ☐ ☐
52. experiencing frequent headaches or chronic pain ______ ☐ ☐
53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) ______ ☐ ☐
54. considered a touchy/sensitive person ______ ☐ ☐
55. often unhappy or depressed ______ ☐ ☐
56. taking birth control pills ______ ☐ ☐
57. currently pregnant ______ ☐ ☐
58. diagnosed with a prostate disorder ______ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) ______

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______ Date ______

Doctor's Signature ______ Date ______

ASA ______ (1-6) ○ ○ ○

DELICATE DENTISTRY
of Palm Harbor

DENTAL HISTORY

Patient Name ______________________ Nickname ______________________ Age __________

Referred by ______________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist ______________________ How long have you been a patient? ______________ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ___/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?	☐	☐

GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐	☐

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT	YES	NO
21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	☐	☐
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore?	☐	☐
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature ______________________________________ Date __________

Doctor's Signature ______________________________________ Date __________