**JONATHAN T. BLOCH D.M.D.**
**General & Aesthetic * Restorative Dentistry**
*Uniquely experienced, capable & dedicated care for beautiful, healthy smiles*

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13722 S.W. 84 Street Miami, FL. 33183
(305) 385- 5555

# PATIENT REGISTRATION

| | | | | | |
|---|---|---|---|---|---|
| Date | | | | | |
| Name | | | | | |
| Address | | | | | |
| City | | State | | Zip | |
| Phone Number | | Work Number | | Mobile Number | |
| Date of Birth | | Sex | | Occupation | |
| Marital Status | | Spouse's Name | | | |
| Dental Insurance | | Phone Number | | | |
| Policy # | | Subscriber SSN | | | |
| Subscriber Name | | Subscriber Date of Birth | | | |
| Secondary Insurance | | Responsible Party | | | |
| Email | | Referred by | | | |
| In case of emergency | | | | | |
| Name | | Contact Number | | | |

## DENTAL HEALTH

| | |
|---|---|
| Reason for visit | |
| When was your last visit? | |
| Have you ever had any serious problem associated with previous dental treatment? | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| How often you brush your teeth? | | | | | | | | | |
| What texture brush do you use? | | Soft | | Medium | | Hard | | Nylon | | Natural |
| How often do you floss? | | | | | | | | | |
| Do your gums bleed when brushing or flossing? | | | | | | | | | |
| Do you avoid brushing any part because of pain? | | | | | | | | | |

| | | | | |
|---|---|---|---|---|
| Do you feel twinges of pain when your teeth come into contact with: | | | | |
| a) hot foods or liquids i.e. soup, coffee, tea, etc. | | Yes | | No |
| b) cold foods or liquids i.e. ice cream, cold fruit, etc. | | Yes | | No |
| c) sweets i.e. candy, fruit, sweet desserts, etc. | | Yes | | No |
| d) sours i.e. lemons, limes, grapefruit | | Yes | | No |

| | | | | |
|---|---|---|---|---|
| Do you feel pain when you brush or floss? | | Yes | | No |
| Do you chew on only one side of your mouth? | | Yes | | No |
| If you do, please explain. | | | | |

| | | | | |
|---|---|---|---|---|
| Do your gums feel tender or sore? | | Yes | | No |
| Do you clench or grind your jaws while sleeping? | | Yes | | No |
| Do your jaws ever feel tired? | | Yes | | No |
| Do you wear dentures? | | Yes | | No |
| Do you usually have many cavities? | | Yes | | No |
| Do you lose or break fillings? | | Yes | | No |
| Do you gag easily? | | Yes | | No |

| |
|---|
| Remarks |

**HEALTH HISTORY**

| | | | | |
|---|---|---|---|---|
| Date of last health care exam? | | | | |
| What was this exam for? | | | | |
| Have you been hospitalized in the last 5 years? | | No | | Yes |
| If yes, reason: | | | | |
| | | | | |
| Are you currently receiving care? | | No | | Yes |
| If yes, nature of care: | | | | |
| | | | | |
| Please list all the names and phone numbers of the physicians who are currently providing you care: | | | | |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| | | | | |
| *Please mark with ✓on the following condition/s you may have or had in the past. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.* | | | | |
| | Anemia or Blood Disorder | | Hepatitis, any form | |
| | Arthritis, Rheumatism or other Inflammatory Disease | | Joint Replacement | When placed? |
| | Asthma | | Kidney Disease | |
| | Abnormal Bleeding from a cut | | Liver Disease (including Jaundice) | |
| | Cancer or Tumor | | Sore/Enlarged Lymph Nodes | |
| | Diabetes | | Psychosis | |
| | Emphysema or other Respiratory/ Lung Illnesses | | Previous Biopsies | |
| | Epilepsy | | Radiation or Chemotherapy Treatment | |
| | Fainting or Dizzy Spells | | Rheumatic Fever | |
| | Glaucoma | | Slow-Healing Mouth Sores | |
| | Abnormal Heart or Previous Bacterial Endocarditis | | Unintentional Weight Loss/Gain | |
| | Heart Valve (artificial) or Heart Transplant | | H.I.V. Infection/AIDS or ARC | |
| | Congenital Heart Disease | | Venereal Disease | |
| | Heart Disease, Heart Attack, Heart Surgery | | Other Conditions | |
| | Heart Stent *When placed?* | | Recurrent Illnesses | |

| Are you taking any of these medications? | |
|---|---|
| | Pre-medication before dental treatment |
| | Antacids |
| | Dilantin or Tegretol |
| | Barbituates (any) |
| | St. John's Wort or Kava-Kava |
| | Tagamet (cimetidine) or Prilosec (omeprazole) |
| | Cardizem (diltiazem) or Calan, Isoptin (Verapamil) |
| | Serzone (nefazodone) |
| | Diflucan (fluconazole) or Sporonox (itraconazole) |
| | Biaxin (clarithromycin) |
| | Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva<br>If so, when did the treatment begin? When did it end? |
| | Have you ever taken any prescription drugs such as fen-phen for weight loss? |
| | Do you consume grapefruit juice, grapefruits or grapefruit extract? |

| Please list any medications you are currently taking and dosages: | |
|---|---|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

| Please list any dietary or herbal supplements you are taking for what purpose: | |
|---|---|
| 1. | 3. |
| 2. | 4. |

| | | | | | |
|---|---|---|---|---|---|
| **Women:** Are you pregnant? | No | Yes | Are you a nursing mother? | No | Yes |
| Are you planning a pregnancy soon? | No | Yes | Are you taking birth control pills? | No | Yes |
| Abnormal Blood pressure? | No | Yes | Have you ever been diagnosed with "high Blood pressure"? | No | Yes |
| What is your normal Blood pressure? S_____/D_____ | | | Today: S_____/D_____ | | |

| Are you allergic or have you had a reaction to: | | | | | |
|---|---|---|---|---|---|
| Local anesthetics? | No | Yes | Codeine, Valium, or other sedatives? | No | Yes |
| Penicillin or any other antibiotics? | No | Yes | Latex or Metals? | No | Yes |
| Aspirin, Ibuprofen, or Tylenol? | No | Yes | Others (please Specify) | | |

| | | | |
|---|---|---|---|
| **Tobacco, Alcohol, Drugs** | | | |
| Do you use tobacco? If yes, circle type: Smoke Chew How much per day? | | Yes | |
| Do you want to quit using tobacco? | | Yes | |
| Do you consume alcohol? If yes, approximately how many alcoholic beverages per week? | | | |
| Do you use any mood altering drugs other than those previously listed? | | | |

| Weight and dietary considerations | | | |
|---|---|---|---|
| Weight | Meals per day | Dietary restrictions | Food allergies |
| | | | |
| Sugar in your diet (circle one): *None Slight Moderate High* | | | |

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the health care provider or agency, who may release information to you. I also give permission to release my records to other health care providers or agencies as part of my treatment. I will notify the doctor of change in my health and medications.*

_____ _____ _____

*Patient (Print Name)* *Patient Signature* *Date*

## OFFICE FINANCIAL POLICY

PATIENT FINANCIAL OBLIGATION/CO-PAY IS DUE AT TIME SERVICES ARE RENDERED.

PLEASE BE ADVISED THAT ANY APPOINTMENTS NOT CANCELLED WITH A 48 HOUR NOTICE WILL BE CHARGED AN OFFICE FEE OF $100.

PLEASE BE ADVISED THAT ALL OUTSTANDING ACCOUNT BALANCES, WITHOUT PRIOR FINANCIAL PAYMENT ARRANGEMENTS, WILL BE SUBJECT TO 1.5% INTEREST CHARGE PER MONTH – 18% A YEAR.

_____ _____ _____

*Patient (Print Name)* *Patient Signature* *Date*

**DOCTOR'S USE ONLY**

Comments on patient interview concerning medical history:

_____

_____

Significant findings from questionnaire or oral interview:

_____

_____

Dental management considerations

_____

_____

_____ _____ _____

*Doctor (Print Name)* *Doctor Signature* *Date*