Confidential New Patient Information

Patient's Name _____ Age_____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

E-mail _____ Best Contact **EMAIL CELL TEXT HOME** Best Time to Reach You _____

SS# _____ Marital Status: **SINGLE MARRIED WIDOWED DIVORCED**

Employer _____ Employer Address _____

Spouse's Name _____ Spouse's Phone: (Work) _____ (Cell) _____

Emergency Contact _____ Relation _____ Emergency Phone _____

Do you have dental insurance? **YES NO**

If YES, Insurance Carrier's Name _____

Group # _____ Ins Phone# _____

Subscriber's Name _____ Relation to Patient _____

Subscriber's SS# _____ Subscriber's Date of Birth _____

Employer/Co. Name_____ Phone _____

Employer/Co. Address, City, State, Zip _____

Insurance Carrier Address,City,State,Zip _____

HOW DID YOU HEAR ABOUT US? _____

Would you like to receive appointment reminders via text message? **YES NO**

Would you like to become friends with the Cavka Dental Center on facebook.com to receive special offers? **YES NO**

_____

SIGNATURE OF PATIENT OR GUARDIAN **PRINT NAME** **DATE**

2511 St. Johns Bluff Rd S Unit 206
Jacksonville, FL 32246

904 329 3371
www.CavkaDentalCenter.com
info@CavkaDentalCenter.com

Cavka
DENTAL CENTER

Medical History

In order for us to provide you with the safest and best possible care, please complete these Medical & Dental History forms. All information is kept strictly confidential.

Have you taken any prescription drugs during the last 6 months? Please list. _____ **YES NO**

_____

_____

Are you taking any over the counter medications or herbal supplements? Please list. _____ **YES NO**

_____

Are you allergic to (i.e. itching, rash, swelling of hands, feet, eyes) or made sick by any medication? _____ **YES NO**

Please list _____

Any surgeries and/or hospitalizations? _____ **YES NO**

Have you ever had any excessive bleeding requiring special treatment? _____ **YES NO**

Have you ever taken drugs by mouth or by injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer?_____ **YES NO**

Have you ever been told to take antibiotics prior to dental treatment? _____ **YES NO**

Use of alcohol: **YES NO | DAILY WEEKLY MONTHLY** Use of recreational drugs: _____ **YES NO**

Do you use tobacco? What type and how much per day? _____ **YES NO**

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE AT THE PRESENT OR HAVE HAD IN THE PAST:

☐ **LOW / HIGH BLOOD PRESSURE**	☐ **KIDNEY PROBLEMS**	☐ **THYROID / GLAND PROBLEMS**	☐ **ANEMIA**
☐ **HEART DISEASE / ATTACK**	☐ **SEXUALLY TRANSMITTED DISEASES**	☐ **SEIZURES / EPILEPSY**	☐ **LEUKEMIA**
☐ **ANGINA PECTORIS**	☐ **ACID REFLUX**	☐ **ALLERGIES / SINUS TROUBLE**	☐ **BRUISE/BLEED EASILY**
☐ **ARTIFICIAL HEART VALVE**	☐ **ULCERS**	☐ **ASTHMA / BRONCHITIS**	☐ **OSTEOPOROSIS**
☐ **HEART PACEMAKER**	☐ **HEPATITIS / JAUNDICE**	☐ **EMPHYSEMA / COPD**	☐ **ARTHRITIS**
☐ **HEART SURGERY**	☐ **LIVER FAILURE**	☐ **CHEMOTHERAPY**	☐ **JOINT REPLACEMENTS**
☐ **STENTS**	☐ **DIABETES TYPE I OR II**	☐ **RADIATION TREATMENT**	☐ **STROKE**

Are you pregnant now? **YES NO**	Practicing birth control? **YES NO**	Plan to become pregnant? **YES NO**

PLEASE READ THE FOLLOWING CAREFULLY: To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetic or pre-medications which may be deemed advisable.

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Cavka DENTAL CENTER

Dental History

Answers to these questions help us provide safe and effective dental care personalized to your individual needs.

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:

1. Sensitivity to Hot or cold? . . . . . **YES NO**
2. Sensitivity to Sweets? . . . . . **YES NO**
3. Pain with Biting or chewing? . . . . . **YES NO**
4. Mouth odors or bad taste? . . . . . **YES NO**
5. Bleeding / Hurt Gums? . . . . . **YES NO**
6. Clench or grinding your teeth? . . . . . **YES NO**
7. Clicking or popping of the jaw? . . . . . **YES NO**
8. Pain in the jaw joint area near the ear? . . . . . **YES NO**
9. Difficulty in opening or closing your mouth? . . **YES NO**
10. Head, neck, or shoulder aches? . . . . . **YES NO**

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY:

- ☐ **CHECK UP**
- ☐ **CLEANING**
- ☐ **TOOTH PAIN**
- ☐ **ORTHODONTICS [BRACES]**
- ☐ **WHITENING**
- ☐ **COSMETIC DENTISTRY**
- ☐ **SLEEP DENTISTRY**
- ☐ **IMPLANTS**
- **OTHER** _____

I WOULD LIKE TO LEARN MORE ABOUT:

- ☐ **COSMETIC DENTISTRY**
- ☐ **VENEERS**
- ☐ **WHITENING**
- ☐ **CROWNS**
- ☐ **IMPLANTS**
- ☐ **DENTURES**
- ☐ **SLEEP DENTISTRY**
- ☐ **SMILE MAKEOVER**
- **OTHER** _____

When was your last dental visit? _____

What was completed during your last dental visit? _____

Last dental x-rays?_____ How often do you have dental examinations ? _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you have any dental problems that you are aware of now? If yes, please describe. _____

_____

Do you feel nervous about dental treatment? If yes, what is your biggest concern? _____

_____

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