General & Cosmetic Dentistry of Tampa

Randall A. Diez, DMD PA
Michael A. Diez, DMD

Date________________

PATIENT INFORMATION

Name: Dr. / Mr. / Mrs. / Ms.____ Email:________________
Last First Middle

Home Address:______________________________________ Home Phone:________________

City:____________________ State:__________ Zip:__________ Cell Phone:________________

Employer:______________________________ Occupation:________________________

Date of Birth:______________ Age:_____ Sex:_____ Marital Status:_____ SS#:________________

Spouse/ Parent Employer:__________________________________ Date of Birth:______________

Dental Insurance:______________ Name of Policyholder:______________ ID#:______________

Who Referred You To Us?____

Previous Dentist / Address____________________________________ Phone:______________

MEDICAL HEALTH

Physician's Name:____________________________________ Phone:______________

Physician's Address:____

Last Physical:______________ Findings:________________________________

Emergency Contact:__________________________________ Phone:______________

Are you presently taking any medications? ❏ Yes ❏ No Type/Purpose________________________

Are you allergic to any medications? ❏ Yes ❏ No If so, please list________________________

Do you have, or had any of the followings:

	Yes	No		Yes	No
Heart Disease	❏	❏	Are you a smoker or ever been?	❏	❏
Bacterial Endocarditis	❏	❏	Artificial heart valve or hip	❏	❏
Abnormal Blood Pressure	❏	❏	Hepatitis	❏	❏
Ulcers	❏	❏	Asthma or Hay fever	❏	❏
Tuberculosis or Lung Disease	❏	❏	Sinus Trouble	❏	❏
Diabetes	❏	❏	Arthritis	❏	❏
Epilepsy	❏	❏	Stroke	❏	❏
Blood Disease (Anemia)	❏	❏	Glaucoma	❏	❏
Congenital Heart Lesions	❏	❏	Fainting	❏	❏
Tumor History	❏	❏	Are you pregnant	❏	❏
Autoimmune Disorders	❏	❏	Acquired Immune Deficiency HIV/AIDS	❏	❏
Are you subject to prolonged/excessive bleeding	❏	❏	Radiation Therapy or Chemotherapy	❏	❏

DENTAL HEALTH

Date of last dental exam:____

What is your immediate dental concern or reason for today's appointment?________________________

Do you have any specific questions concerning your health, teeth or gums?________________________

Patient Signature________________________