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
Heart Disease	❑	❑
Bacterial Endocarditis	❑	❑
Abnormal Blood Pressure	❑	❑
Ulcers	❑	❑
Tuberculosis or Lung Disease	❑	❑
Diabetes	❑	❑
Epilepsy	❑	❑
Blood Disease (Anemia)	❑	❑
Congenital Heart Lesions	❑	❑
Tumor History	❑	❑
Autoimmune Disorders	❑	❑
Are you subject to prolonged/excessive bleeding	❑	❑
Are you a smoker or ever been?	❑	❑
Artificial heart valve or hip	❑	❑
Hepatitis	❑	❑
Asthma or Hay fever	❑	❑
Sinus Trouble	❑	❑
Arthritis	❑	❑
Stroke	❑	❑
Glaucoma	❑	❑
Fainting	❑	❑
Are you pregnant	❑	❑
Acquired Immune Deficiency HIV/AIDS	❑	❑
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________________________