3720 NW 43rd St, Suite 102
Gainesville, FL 32606

Ada Parra, DDS, MS
Justin Craighead, DMD, MS

PATIENT INFORMATION

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as thoroughly as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date: Phone: Cell:

Name: Soc. Sec. #
(Last name) (First Name) (Middle Initial)

Address: City: State: Zip:

Sex: ☐ Male ☐ Female Age: Birthdate:

Please provide your e-mail address if you wish to receive information from us about future promotions, newsletters, education materials, etc.:

Patient's e-mail address:

☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Partner ☐ Minor

Patient Employer/School: Occupation:

Emergency Contact: Phone:

Please provide the name of any person or persons you wish to grant permission to Premier Dental Team the ability to discuss person, insurance, financial, or dental treatment plan information with (i.e., spouse, parent, guardian, other relative, etc.)

_____

Whom may we thank for referring you?

PRIMARY DENTAL INSURANCE

Person responsible for account:
(Last Name) (First Name) (Middle Initial)

Relation to patient: Birthdate: Soc Sec #:

Address (If different from patient): City:

State: Zip: Phone:

Person Responsible Employed By: Occupation:

Insurance Company: Member #:

INSURANCE AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to Premier Dental Team all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions. Premier Dental Team may use my health care information and disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

ADDITIONAL INSURANCE

Person Responsible:
(Last Name) (First Name) (Middle Initial)

Relation to Patient: Birthdate: Soc Sec #

Address (If different from patient's): City: State:

Zip: Phone:

Person Responsible Employed By: Occupation:

Insurance Company: Member #:

(P) 352-372-3600 (F) 352-372-8933 info@thepremierdentalteam.com

PREMIER DENTAL TEAM

DENTAL HISTORY

Reason for today's visit: Date of last dental care:

Former Dentist: Date of last dental x-rays:

Check if you have had problems with any of the following:

☐ Bad Breath ☐ Bleeding Gums ☐ Clicking or Popping Jaw ☐ Food Collection Between Teeth
☐ Grinding Teeth ☐ Loose or Broken Fillings ☐ Periodontal Treatment ☐ Sensitivity to Cold
☐ Sensitivity to Hot ☐ Sensitivity to Sweets ☐ Sensitivity to Biting ☐ Sores or Growths in your mouth

How often do you floss? How often do you brush?

MEDICAL HISTORY

Physicians Name: Date of Last Visit:

1. Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonomin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No
2. Do you currently (or have you in the past) taken any Bisphosphonates (e.g. Boniva, Fosamax, Actonel)? ☐ Yes ☐ No
3. Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe:
4. Have you had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates:
5. (Women) Are you Pregnant? ☐ Yes ☐ No - Nursing? ☐ Yes ☐ No - Taking Birth Control? ☐ Yes ☐ No

Check if you have had problems with any of the following:

☐ Anemia
☐ Arthritis/Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of breath
☐ Skin rash
☐ Stroke
☐ Swelling of feet
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsilitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease

(P) 352-372-3600 (F) 352-372-8933 info@thepremierdentalteam.com

PREMIER DENTAL TEAM

MEDICATIONS
List Medications you are currently taking:

ALLERGIES
List allergies you have below:

MEDICAL HISTORY FORM AUTHORIZATION

Please provide your signature below to indicate you have completed this medical history form to the best of your knowledge and ability and have provided Premier Dental Team accurate and thorough information regarding your medical history and contact information. We are required to ask you to update this form once every 12 months.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date