Sunshine Family Dentistry
408 W Interlake Blvd
Lake Placid, FL 33852
Ph # : 863-465-2037
Fax # : 863-840-1155

Patient Personal Information

Title | Preferred Name | Birth Date | Age
Last, First | Marital Status | Sex
Address | Home # | Work #
Cell # | Drive Lic.
City, State, Zip | Emergency Contact | Emergency Phone #
Email | Student | SSN
Health Care Guardian Name | School Name
Health Care Guardian Phone # | Referral Type

Person responsible/guarantor for paying bills

Title | Preferred Name | Birth Date | Age
Last, First | Marital Status | Sex
Address | Home # | Work #
Cell # | Drive Lic.
City, State, Zip | SSN
Email

Do you have Primary Dental Insurance? ___Yes ___No

Group No/Name
Insurance Name
Phone #
Employer Name
Subscriber Last, First
Subscriber Address
City, State, Zip
Relationship to Patient | Birth Date
Subscriber ID

Do you have Secondary Dental Insurance? ___Yes ___No

Group No/Name
Insurance Name
Phone #
Employer Name
Subscriber Last, First
Subscriber Address
City, State, Zip
Relationship to Patient | Birth Date
Subscriber ID

Patient Medical Information

Allergic To

- ☐Y ☐N No Known Allergies
- ☐Y ☐N Aspirin
- ☐Y ☐N Barbiturates / Sleeping Pills
- ☐Y ☐N Codeine
- ☐Y ☐N Erythromycin
- ☐Y ☐N Iodine
- ☐Y ☐N Latex Rubber
- ☐Y ☐N Local Anesthetics
- ☐Y ☐N Metals
- ☐Y ☐N No Epinephrine
- ☐Y ☐N Penicillin
- ☐Y ☐N Sulfa Drugs
- ☐Y ☐N Other Narcotics
- ☐Y ☐N Environmental Allergies

Check if applicable

- ☐Y ☐N Anemia
- ☐Y ☐N Ankles Swell
- ☐Y ☐N Anorexia
- ☐Y ☐N Arteriosclerosis
- ☐Y ☐N Arthritis
- ☐Y ☐N Asthma
- ☐Y ☐N Autoimmune Disease
- ☐Y ☐N Bladder Trouble
- ☐Y ☐N Blood Clotting Problems
- ☐Y ☐N Blood Transfusion
- ☐Y ☐N Bulimia
- ☐Y ☐N Bronchitis
- ☐Y ☐N Cancer / Tumor or Growth
- ☐Y ☐N Cardiovascular Disease
- ☐Y ☐N Chemotherapy
- ☐Y ☐N Chest Pain Upon Exertion
- ☐Y ☐N Epilepsy
- ☐Y ☐N Fainting Spells
- ☐Y ☐N Fever Blisters
- ☐Y ☐N Frequent Headaches
- ☐Y ☐N Frequently Dry Mouth / Sjogren
- ☐Y ☐N Gag Reflex
- ☐Y ☐N Gall Bladder Trouble
- ☐Y ☐N Hay Fever
- ☐Y ☐N Heart Attack
- ☐Y ☐N Heart Disease
- ☐Y ☐N Heart Murmur
- ☐Y ☐N Hepatitis
- ☐Y ☐N Herpes
- ☐Y ☐N High Blood Pressure
- ☐Y ☐N Hives
- ☐Y ☐N Jaundice
- ☐Y ☐N Mitral Valve Prolapse
- ☐Y ☐N Pacemaker
- ☐Y ☐N Premedicate *See Notes*
- ☐Y ☐N Radiation Treatment
- ☐Y ☐N Rheumatic Fever
- ☐Y ☐N Rheumatic Heart Disease
- ☐Y ☐N Rheumatoid Arthritis
- ☐Y ☐N Seizures
- ☐Y ☐N Sexually Transmitted Disease
- ☐Y ☐N Shortness of Breath
- ☐Y ☐N Skin Rash
- ☐Y ☐N Sinus Trouble
- ☐Y ☐N Stomach Ulcers
- ☐Y ☐N Stroke
- ☐Y ☐N Thyroid Problems
- ☐Y ☐N Tuberculosis

☐ Y ☐ N Any changes since last visit?
☐ Y ☐ N Are you taking any medications
☐ Y ☐ N Any Additional Known Condition
☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Angina
☐ Y ☐ N Color Blindness
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Contact Lenses
☐ Y ☐ N Congestive Heart Failure
☐ Y ☐ N Damaged Heart Valve
☐ Y ☐ N Diabetes
☐ Y ☐ N Emphysema
☐ Y ☐ N Joint Replacement *See Notes*
☐ Y ☐ N Kidney Issues
☐ Y ☐ N Leukemia
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lupus
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Unusual Weight Loss
☐ Y ☐ N Urinate Frequently

Other

☐ Y ☐ N See Scanned Documents: Pt Note

Additional Comments

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist _____

Phone _____

Last exam date _____

Approximate date of last x-rays _____

Date of your last cleaning _____

Do your gums bleed while brushing or flossing ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? _____

Have you ever had burning of the tongue or cracking of the corners of your mouth ? _____

Do you chew/smoke tobacco in any form ? _____

Have you had any head, neck or jaw injuries ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____

Do you clench or grind your teeth ? _____

Have you ever had orthodontic treatment ? _____

If Yes, approximate date of placement _____

Do you wear dentures or partials ? _____

If Yes, approximate date of placement of dentures ? _____

Are you having any specific problems with your teeth, gums, or mouth at this time ? _____

Are you happy with your smile ? _____

Do you have problems with teeth/fillings breaking ? _____

Do you regularly use dental floss ? _____

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ? _____

Do you have difficulty in opening your mouth widely ? _____

Do you have an unpleasant taste or odor in your teeth/mouth ?	
Does food catch between your teeth ?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	

Medical Questionnaire

Emergency Contact	
Emergency contact name	
Emergency contact phone	
Emergency contact relationship to patient	
Medical Questionnaire	
Family Physician	
Phone	
Are you currently under care of a Physician ?	
If Yes, what is the condition being treated ?	
Have you had any serious illness, operation or been hospitalized within the past 5 years ?	
If Yes, what illness or problem ?	
Are you currently taking any medication ?	
If Yes, what ?	
Do you have a condition where you premedicate for?	
If yes, please specify the medication	
Are you on any GLP-1 medication? (Ozempic, Monjaro, ..)	
Did you have a joint replacement?	
If yes, please specify the date	
Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)	
Have you ever taken the diet control drug Fen-Phen ?	
Do you use alcoholic beverages ?	
Do you smoke ?	
Women Only	
Are you pregnant?	
If Yes, what is your due date ?	
Are you currently nursing ?	
Do you have menstrual period problems ?	
Are you on hormone replacement therapy ?	
Are you on birth control pills / fertility drugs ?	
Additional Comments	

Any Disease, Condition or Problem not Listed ? Please list

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**

Dentist Signature **Date**