Dr. Ruth Rojas
Prosthodontics & Cosmetic Dentistry
3400 S. Tamiami Trail, Suite 301 Sarasota, FL 34239
Ph: (941) 951-7711

Today's date:					E-mail:		
PATIENT INFORMATION							
Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Street address:	City:	State:	ZIP Code:	Weight:	Age:	Sex: ❑ M ❑ F	
Birth date: / /	Home No.:	Work No.:	Cell:	Social Security No.:			
Occupation:	Spouse Name:	Spouse Phone No.:	Spouse Birth Date: / /				

Referred to Dr.Rojas by:

❑ Webpage ❑ Yelp ❑ Google ❑ Facebook ❑ Referral ❑ Magazine Publication

❑ Other: ……..

DENTAL INFORMATION

What is your chief complaint (reason for today's appointment):

Is there anything you'd like to change about your smile?

Date of your last dental exam: / /	Date of your last cleaning: / /	Are you in any discomfort or pain at this time ❑ Yes ❑ No	Date of last dental X-rays: / /

Have you ever had any problems associated with any previous dental care? ❑ Yes ❑ No
If yes, please explain:

Are you able to chew foods satisfactorily: ❑ Yes ❑ No	Do you have headaches, earaches or neck pain? ❑ Yes ❑ No	Do you fear dental treatment: ❑ Yes ❑ No

Do you now have or have you had any of the following? Please indicate yes with an (x)

❑ Teeth sensitive to cold/hot/sweet	❑ Bleeding Gums	❑ Food impaction
❑ Clenching or grinding	❑ Burning of tongue/mouth	❑ Swelling or lump in mouth
❑ Blisters on lips/mouth	❑ Bad breath	❑ Unpleasant taste
❑ Clicking/popping of the jaw joint	❑ Periodontal (gum) treatment	❑ Orthodontic treatment (braces)
❑ Endodontic treatment (root canal)	❑ Complications with extractions	❑ Use chewing tobacco
❑ Use chewing gum	❑ Difficulty opening jaw	❑ Use denture adhesive
❑ Fluoride supplements	❑ Use mouthwash	❑ Use floss daily
❑ Do you brush daily	❑ Use grind your teeth	❑ Smoke cigarettes, pipe, cigar, marijuana

MEDICAL INFORMATION

Are you under the care of a physician? ❑ Yes ❑ No	Name of Physician:	Address of Physician:	Phone No. of Physician: ( )

Your last physical examination was on (approximate date): / /	Preferred Pharmacy:	Are you in good Health? ❑ Yes ❑ No

Has there been any change in your general health within the past year? ❑ Yes ❑ No
If yes, what condition is being treated?

Have you had a serious illness, operation or been hospitalized in the past 5 years? ❑ Yes ❑ No
If so, please list illness/operation with date (year)

Please mark (x) your response to indicate if you have or have had any of the following:

❑ Do you wear contact lenses/glasses? ❑ Do you use controlled substances drugs?

❑ Have you ever been told to take an antibiotic before a dental treatment? ❑ Yes ❑ No

❑ Have you ever had an orthopedic total joint (hip, knee, elbow, or finger) replacement? If so, please list the date
/ /

Are you currently or have you EVER taken any of the following Medications: Aredia, Boniva, Actonel, Fosamax, Reclast Zometa for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? (Please circle)
If so, date treatment began: / /

WOMEN ONLY Are you:

a. Pregnant ❑……
b. Number of weeks ❑……
c. Taking birth control pills or hormonal replacement ❑……
d. Nursing ❑……

Have your or any family member had any ill effects from local or general anesthesia? ❑ Yes ❑ No
Example, (Malignant Hyperthermia) If yes, please explain:
……
……

Allergies – Are you allergic or have you had a reaction to: (To all yes responses, specify type of reaction).

❑Local anesthetics …… ❑ Metals……..
❑ Aspirin…… ❑ Latex (rubber ……..
❑ Penicillin or other antibiotics …… ❑ Animals……
❑ Barbiturates, sedatives, or sleeping pills …… ❑ Food……..
❑ Sulfa drugs…….. ❑ Eggs……
❑ Codeine or other narcotics …… ❑ Other……

Are you taking any of the following?

a. Antibiotics…… ❑ Yes ❑ No
b. Anticoagulants…… ❑ Yes ❑ No
c. Medicine for high blood pressure…… ❑ Yes ❑ No
d. Cortisone or steroids…… ❑ Yes ❑ No
e. Sedative, tranquilizer……..❑ Yes ❑ No
f. Antihistamines…… ❑ Yes ❑ No
g. Aspirin……..❑ Yes ❑ No
h. Insulin or diabetes drug……❑ Yes ❑ No
i. Digitals or drugs for heart trouble…… .❑ Yes ❑ No
j. Nitroglycerin…… ❑ Yes ❑ No
k. Oral contraceptive or other hormonal therapy……..❑ Yes ❑ No
l. Vitamins or other nutritional supplements ……❑ Yes ❑ No

1. Have you had abnormal bleeding associated with extractions, trauma or surgery? ❑ Yes ❑ No
   a. Do you bruise easily? ❑ Yes ❑ No
   b. Have you ever required a blood transfusion? ❑ Yes ❑ No
      If so, please explain the circumstances……
2. Do you have any blood disorder such as anemia or sickle-cell? ..... ❑ Yes ❑ No
3. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck? ❑ Yes ❑ No
4. Are you taking any drug or medicine? ❑ Yes ❑ No

If so, please list all:

……
……

Please check if you have any of the following:

- ❑ Heart attack
- ❑ Heart murmur
- ❑ Rheumatic fever
- ❑ Heart failure
- ❑ Enlarged heart
- ❑ Irregular heart beat
- ❑ Pacemaker
- ❑ Heart valve replacement
- ❑ Defibrillator
- ❑ Asthma
- ❑ Hives or skin rash
- ❑ Fainting spells or seizures
- ❑ Kidney trouble
- ❑ Diabetes
- ❑ Arthritis
- ❑ Stomach ulcers
- ❑ Tuberculosis
- ❑ Glaucoma
- ❑ Cancer or malignancy
- ❑ Osteoporosis
- ❑ Persistent cough or cold
- ❑ Immune deficient disease
- ❑ Hyper or hypothyroidism
- ❑ Sleep apnea
- ❑ Frequent diarrhea
- ❑ High blood pressure
- ❑ Emphysema
- ❑ Bronchitis pneumonia
- ❑ Hepatitis A, B, or C
- ❑ Cirrhosis
- ❑ Organ Transplant
- ❑ Stomach ulcer
- ❑ Gastritis
- ❑ Gastric reflux/ GERD
- ❑ Hiatal hernia
- ❑ Crohn disease
- ❑ Pancreas
- ❑ Pituitary disorder
- ❑ Adrenal failure
- ❑ Stroke
- ❑ Aneurism
- ❑ Seizure
- ❑ Paralysis
- ❑ Leg pain
- ❑ Artery replacements
- ❑ Psychiatric problems
- ❑ HIV
- ❑ Headaches
- ❑ Locking of the jaw
- ❑ Popping of the jaw
- ❑ Alcoholism
- ❑ Drug dependency
- ❑ Venereal disease (syphilis, gonorrhea, HPV)

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell phone no.: ( )

The above information is true to the best of my knowledge. I hereby authorize and request the performance of dental services for myself or for whom I am acting as legal guardian. I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by her supervised staff for diagnostic purposes or dental treatment. I understand that I am financially responsible for any balance for myself or the above named patient. I also authorize Ruth Rojas, DMD to release any information required for my care.

Patient/Guardian signature *Date*