RICHARD C. FLORES, DDS, LLC

34940 RIDGE ROAD SUITE A
WILLOUGHBY, OHIO 44094

www.richfloresdental.com
(440) 975-5774

PATIENT INFORMATION

First Name: | MI | Last Name: | Preferred Name:

Address: | City:

State: | Zip Code: | Birth Date: | SSN:

Home Phone: | Work Phone: | Cell Phone:

Email Address: | Marital Status: | Gender:

Who may we thank for referring you to our office:

Emergency Contact, Name and Phone Number:

Date of your last dental visit and dental cleaning:

DENTAL INSURANCE INFORMATION

Subscribers Name: | Relationship to Subscriber: | Subscribers ID # | Subscribers Birth Date:

Insurance Company: | Employer: | Group #

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MEDICAL INFORMATION

		YES	NO
Physician Name: Phone	Are you in good health?		
	Any changes in your health in the past year?		
	Are you now under the care of a physician?		
Address/ City/State	If YES, what condition is being treated?		
Have you had a serious illness, operation or been hospitalized in the past 5 years? If YES, what was the reason for your hospital visit?			
Please **ALL** medications you are currently taking, including vitamins, natural or herbal preparations and/or diet supplements:			
Please list **ALL** Allergies, Penicillin, Codeine, Latex, Metals, Etc...			

MEDICAL HISTORY

JOINT REPLACEMENT: Have you had an orthopedic total joint replacement? (hip, knee, elbow)
YES ☐ NO ☐ If yes, did your orthopedic surgeon recommend antibiotic premedication prior to dental visits and if so what type of medication?

Please list medication:

Are you taking or scheduled to begin taking either of the meidcations, Alendronte (Fosamx) or Risedroate (Alctonel) for osteoporosis or Paget's disease?	YES	NO
WOMAN ONLY: Are you pregnant?	YES	NO
Nursing?	YES	NO
Are you taking birth control?	YES	NO

Do you use tobacco products? (smoking, snuff, chew) YES NO

If so, how interested are you in stopping?
(Circle one) VERY SOMEWHAT NOT INTERESTED

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Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? YES or NO

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems:

	YES	NO		YES	NO		YES	NO
Artificial (prosthetic) heart valve			Autoimmune disease			Tuberculosis		
Previous infective endocarditis			Rheumatoid arthritis			Cancer		
Diabetes			Systemic lupus			Kidney problems		
Liver Disease			Asthma			Eating Disorder		
Persistent swollen glands in neck			Stroke			Thyroid problem		
Severe headaches/Migraines			GI Reflux/ heartburn			Ulcers		
Cardiovascular disease			Angina			Arteriosclerosis		
Congestive heart failure			Heart attack			Heart murmur		
Pacemaker			Anemia			Hemophilia		
High Blood Pressure			AIDS or HIV infection			Arthritis		
Low Blood Pressure			Mitral valve prolapse			Rheumatic fever		
Rheumatic heart disease			Bronchitis			Hepatitis		
Epilepsy			Emphysema			Neurological disorder		
Mental health disorder			Sinus Trouble			Others not listed...		
Osteoporosis			Sexually transmitted disease					

I attest that all the information I have provided is accurate to the best of my ability.

Signature of Patient/Legal Guardian_____ Date: _____

Print name: _____

Doctors Signature_____Date:_____

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I, (print name) _____ hereby certify that I have read and understand the previous information and that is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behold of my dependents (if any), within 30 days of treatment.

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, personal information and/or insurance coverage, I will inform the office at my next dental appointment without fail.

Signature: _____ Date: _____

If a dependent, Responsible party: _____

Relationship to Patient: _____

The signature above, grants Dr. Richard C. Flores, DDS, LLC and staff, permission to treat said child named.