

Phone: (954) 384-7505
Emergency: (954) 804-7348



Windmill Professional Campus
17130 Royal Palm Boulevard, Suite 3
Weston, Florida 33326

ADVANTAGE DENTAL ESTHETIC GROUP
Family and Cosmetic Dentistry

Patient Name:	Today's Date:	
Local Address:	Referred By:	
City:	State:	Zip:
Home Phone:	E-mail:	
Occupation:	Cell Phone:	
Employer:	Work Phone:	
Married [] Single [] Divorced []	Name of Spouse:	
Number of Children:		
Your Birthday:	Your Social Security #	
Previous Dentist:		
Address:	Phone:	
Name of dental insurance company:		
Name of legal guardian (If patient is minor):		
Height:	Weight:	Age:
Date of your last medical examination:		
Nearest relative not living with you?		

Concerning fee for service dentistry, are you aware that you are responsible for all fees at the time treatment is rendered, unless prior arrangements are made? Yes [] No []

Method of Payment (Circle one) Cash Visa Mastercard Other

Consent for Treatment

I hereby certify that I can read, speak, and understand the English language and hereby grant my permission to Dr. Yelena Prato and/or his associates and their staff to administer to myself, my child, or my legal ward, such medications and procedures that they deem necessary, in their professional judgement, for my oral or dental health. Also, I grant my permission for them to administer local anesthetics and other medically indicated drugs or pharmaceutical they deem necessary, to use such operative and technical procedures necessary to complete a diagnosis and/or recommended and accepted treatment has been approved. I also grant my permission to acquire and use all or any part of my records, photographs, videotapes or films which may be required for examination, diagnosis, treatment, instruction and/or scientific publication. For any purpose whatsoever, in any medium now known or in the future invented. I hereby release, discharge, and agree to hold harmless Advantage Dental Esthetic Group/ Dr. Jorge E. Mesa and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio or photographic production.

Date: _____ **Signature:** _____

Medical History

Family Physician:	Specialty:
Address:	Phone:
In case of emergency, notify:	Name:
Relationship:	Phone #:

Please Circle "Y" for yes or "N" for no:

- | | | |
|---|--|---|
| <p>Y N</p> <p>1. Y N Medical Problem</p> <p>2. Y N Heart Trouble</p> <p>3. Y N Heart Murmur</p> <p>4. Y N Rheumatic Fever</p> <p>5. Y N High Blood Pressure</p> <p>6. Y N Low Blood Pressure</p> <p>7. Y N Pain in Chest</p> <p>8. Y N Shortness of Breath</p> <p>9. Y N Swollen Ankles</p> <p>10. Y N Anemia</p> <p>11. Y N Headaches</p> <p>12. Y N Supervised Diet</p> <p>13. Y N Alcohol Dependency</p> | <p>Y N</p> <p>14. Y N Stroke</p> <p>15. Y N Diabetes</p> <p>16. Y N Fainting/Dizziness</p> <p>17. Y N Insomnia</p> <p>18. Y N Nervous Disorder</p> <p>19. Y N Asthma/Hay fever</p> <p>20. Y N Tuberculosis</p> <p>21. Y N Hepatitis</p> <p>22. Y N Arthritis</p> <p>23. Y N Tumor/Cancer</p> <p>24. Y N Excessive Bleeding</p> <p>25. Y N Prosthetic Replacement</p> <p>26. Y N Tobacco Dependency</p> | <p>Y N</p> <p>27. Y N Major Operation</p> <p>28. Y N Serious Accident</p> <p>29. Y N HIV+</p> <p>30. Y N Change in weight</p> <p>31. Y N Easily Fatigued</p> <p>32. Y N Ulcers</p> <p>33. Y N Cough</p> <p>34. Y N Communicable Disease</p> <p>35. Y N Liver Problems</p> <p>36. Y N Psychiatric Treatment</p> <p>37. Y N Kidney Problem</p> <p>38. Y N Drug Dependency</p> <p>39. Y N Medication Allergies</p> |
|---|--|---|

Women:

- 1.-) Y N **Pregnant? _____ Months**
- 2.-) Y N **Miscarriage _____**
- 3.-) Y N **Menopause/Supportive Medication _____**

If yes, please explain (By number):

List all medication (include aspirin, sleeping medication, sedative):

Taking:	For:
Taking:	For:
Taking:	For:

Do you need to be pre-medicated?

Y N - Medication: _____ For: _____

Are there any medical concerns or life style situations that you would like to discuss?

Date: _____ **Signature:** _____

New Patient Dental History

Patient's Name: _____ Today's Date: _____

The following are intended to assist us in providing you with the most comprehensive and preventive dental care according to your present dental condition and your expectations of high quality personal dental care. Please answer each question by placing a circle around the most appropriate answer(s). Thank you.

- 1.-) When was your most recent prophylaxis? (Teeth cleaning)
Over 2 years ago Over 1 year ago Within the last year

- 2.-) Are you presently in any dental pain? Yes No

- 3.-) I am interested in a comprehensive dental examination to determine the present condition of my teeth and supporting tissues, the presence of any disease or infection and to determine what, if any, treatment I need? Yes No

- 4.-) I plan to have recommended dental treatment completed as soon as possible? Yes No

- 5.-) I am only interested in the "no charge" or "free" services as offered by my dental plan? Yes No

- 6.-) My teeth and their appearance could be improved. I am interested to learn about the latest developments in improving my smile and the appearance of my teeth? Yes No

- 7.-) Right now, my priorities and capabilities do include getting any teeth restored to their original, natural condition as soon as possible. Yes No

- 8.-) I plan to have my teeth repaired, restored or the missing ones replaced at the present time. Yes No

- 9.-) I would like to have any disease present in my mouth examined, diagnosed, identified and treated as soon as possible, even if I have to pay for such treatment out of my own pocket. Yes No

Over Please

- | | | |
|--|-----|----|
| 10.-) Have you ever had orthodontic treatment? | Yes | No |
| 11.-) Do you have any growths or swellings in your mouth? | Yes | No |
| 12.-) Do your gums bleed when brushing your mouth? | Yes | No |
| 13.-) Have you ever had a bad reaction to a dental anesthetic? | Yes | No |
| 14.-) Are you aware of stiff neck muscles? | Yes | No |
| 15.-) Are you aware of clenching your teeth during daytime hours? | Yes | No |
| 16.-) Have you ever been told you grind your teeth during sleep? | Yes | No |
| 17.-) Are you aware of your jaw clicking or popping while eating or yawning? | Yes | No |
| 18.-) Do you have difficulty in opening your mouth widely? | Yes | No |
| 19.-) Do you have an unpleasant taste or odor in your mouth? | Yes | No |

Patient's signature: _____

Today's Date: _____