Phone: (954) 384-7505

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** ☐ **Number of Children:**	**Name of Spouse:**	
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. Yelena Prato 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:

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

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: _____