Klement Family Dental
7650 38th Avenue North
St. Petersburg, FL 33710

(727) 343-8831 phone
(727) 345-5396 fax
www.StPeteDentist.com

Patient History (Adult)

Date: ____-____-_______

Legal Name: ____ Sex: ☐M ☐F

Last Name First Name Middle Initial

Preferred Name: __________________________ DOB: ____-____-______ Driver's License #: ___________________

Social Security #:______-_____-________ ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Address:____ City:________________ State:_______ Zip:___________

Home Phone: ( ) ______-_________ Work Phone: ( ) ______-_________ Cell Phone: ( ) ______-_________

Email: _______________________________________ Preferred Contact #:(please circle) Home Work Cell Email

Employer: _____________________________ Occupation: ____________________________________

Person Responsible for Account:____ SSN#:______________________

Home Phone: ( ) ______-_________ Work Phone: ( ) ______-_________ Cell Phone: ( ) ______-_________

How did you hear about our office? (Please circle one)

Social Media Our website Sign (Drive By) Postcard/flyer Insurance Dentistry From the Heart

Primary Care Physician Prosthodontist Online/Search Engine/Reviews Yellow Pages

Employee (please specify): ____

Referred (please specify): ____

Emergency Contact Person: ___________________________________ Relation: ______________________

Home Phone: ( ) _______-________ Alternate Phone: ( ) ______-________

Marital Status: _________________________ Spouse's Name: ______________________________________

Social Security #:______-_____-________ DOB: ____-____-____

Spouse's Employer: ________________________________ Occupation: _____________________________

Work Phone: ( ) ______-_______Cell Phone: ( ) ______-________

Do you have dental insurance? ______________________ Name of Carrier? ____________________________

Primary Insured Name: ____________________________ DOB:______________ SSN:____________________

Is there a secondary dental insurance plan? ____________ Primary Insured:_____________________________

Please present your insurance card to our front staff to verify coverage and benefits.

Medical History (Adult)

How would you rate your health? Excellent Good Fair Poor

Are you currently under the care of a physician other than for routine care? _____NO _____YES

If yes, please explain: ____

Have you been hospitalized in the past year? _____NO _____YES

If yes, please explain: ____

Name of your physician: __________________________ Phone: ( ) ______-_________

Address: ____Date of last complete exam? _____-_____-___

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Medical History (Adult)

*** Are you allergic to or have adversely reacted to any of the following?** No_____ Yes_____

*** If YES, please check the appropriate substance:**

__Aspirin __ Tylenol __ Codeine __ Local Anesthetic __ Latex

. __ Erythromycin . __ Tetracycline . __ Penicillin . __Keflex
. __ Clindamycin . __ Doxycycline . __ Amoxicillin . __ Ceclor
. __ Z-Pack(Zithromycin) . __ Minocycline . __ Augmentin . __ Cephalexin
. __ Biaxin(Clarithromycin) . __ Ampicillin

*** Are you aware of being allergic to any other medication or substance?** No _____ Yes_____

* If YES, please explain: ____

*** Please list any medications you are currently taking:**

1.____________________ 2._____________________ 3.____________________ 4._____________________

*** Have you been given or have taken or taking any of the following medication:**

_____Fosamax (Alendronate) ____Actonel (Risedronate) ____Boniva (Ibandronate) ____Bonefos (Clodronate) ____Aredia (Pamidronate) _____Zometa (Zoledronic acid)

*** Please check any of the following that you have had or have at present:**

_____Artificial Joints (hip, knee, etc.)
_____Artificial Heart Valve
_____Infectious Endocarditis
_____Congenital Heart Defect
_____Rheumatic or Scarlet Fever
_____Synthetic Vascular Heart Graft
_____Mitral Valve Prolapse
_____Hemodialysis Patients w/
_____Fistula or Shunt
_____Neuro-surgical Shunts
_____Portocaval Shunts
________Heart Murmur (Organic)
_____Heart Murmur (Func./Innocent)
_____Heart Failure or Disease
_____Heart Pacemaker
_____Heart Surgery
_____Heart Attack

_____Intellectual Disability
_____Stroke
_____Asthma
_____Alzheimer's
_____High Blood Pressure
_____Thyroid Disease
_____Kidney Trouble
_____Radiation Treatment
_____Chemotherapy
_____Tuberculosis
_____HIV Positive
_____AIDS
_____ARC
_____Venereal Disease
_____Hepatitis A
_____Hepatitis B

_____Hepatitis C
_____Speech Problems
_____Liver Disease
_____Hemophilia
_____Blood Transfusion
_____Drug Addiction
_____Arthritis
_____Diabetes
_____Bruise Easily
_____Epilepsy or Seizures
_____Psychiatric Treatment
_____Fainting or Dizziness
_____Sinus Trouble
_____Fever Blisters
_____Yellow Jaundice
_____Hyperactivity

ARE YOU SUBJECT TO PROLONGED BLEEDING? No_____ Yes_____

FOR WOMEN ONLY: Are you taking birth control pills? No_____ Yes_____
Are you pregnant? No_____ Yes_____

____
PATIENT'S SIGNATURE

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Patient History (Child)

Date: ____-____-________

Legal Name: ____ Sex: ☐M ☐F

Last Name First Name Middle Initial

Preferred Name: _________________________ DOB: ____-____-______ Social Security #:______-_____-________

Address:____ City:________________ State:_______ Zip:___________

Home Phone: ( ) ______-_________ Work Phone: ( ) ______-_________ Cell Phone: ( ) ______-_________

Email: ____________________________________ Preferred Contact #:(please circle) Home Work Cell Email

How did you hear about our office? ____

Do Both Parents Live Together? ____________ If not, with whom does the child reside?______________________

Mother's Name: ______________________________________ Cell/Alternate Number: ( ) ______-_________

DOB: ____-____-______ Social Security #:______-_____-________ Work Phone: ( ) ______-_________

Father's Name: _______________________________________ Cell/Alternate Number: ( ) ______-_________

DOB: ____-____-______ Social Security #:______-_____-________ Work Phone: ( ) ______-_________

Does your child have dental insurance? ____________________ Primary Insured: __________________________

Is there a secondary dental insurance plan? ________________ Primary Insured:___________________________

Please present your insurance card to our front staff to verify coverage and benefits.

Dental History (Child)

Is this your child's first visit to the dentist? _____NO _____YES

Has your child had problems with past dental treatment? _____NO _____YES

If YES, please explain: ____

How often are your child's teeth brushed? ______________________ By Whom? _____Self _____Parent

Does your child suck his/her thumb, finger, lip, etc? _____NO _____YES

Does your child have a dental condition about which you are concerned? ____________________________________

Medical History (Child)

How would you rate your child's health? Excellent Good Fair Poor

Is your child currently under the care of a physician other than for routine care? _____NO _____YES

If yes, please explain: ____

Has your child been hospitalized in the past year? _____NO _____YES

If yes, please explain: ____

Name of your child's physician: ________________________ Phone: ( ) ______-_________

Address: ______________________________________Date of last complete exam? _____-_____-___

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__ Biaxin(Clarithromycin) __ Ampicillin

*** Are you aware of your child being allergic to any other medication or substance?** No _____ Yes_____

* If YES, please explain: ____

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1.___________________ 2.____________________ 3.____________________ 4.____________________

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_____**Infectious Endocarditis**
_____**Congenital Heart Defect**
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_____Heart Surgery
_____Heart Attack

_____Intellectual Disability
_____Stroke
_____Asthma
_____Alzheimer's
_____High Blood Pressure
_____Thyroid Disease
_____Kidney Trouble
_____Radiation Treatment
_____Chemotherapy
_____Tuberculosis
_____HIV Positive
_____AIDS
_____ARC
_____Venereal Disease
_____Hepatitis A
_____Hepatitis B

_____Hepatitis C
_____Speech Problems
_____Liver Disease
_____Hemophilia
_____Blood Transfusion
_____Drug Addiction
_____Arthritis
_____Diabetes
_____Bruise Easily
_____Epilepsy or Seizures
_____Psychiatric Treatment
_____Fainting or Dizziness
_____Sinus Trouble
_____Fever Blisters
_____Yellow Jaundice
_____Hyperactivity

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FOR WOMEN ONLY: Are you taking birth control pills? No_____ Yes_____
Are you pregnant? No_____ Yes_____

____
PARENT'S SIGNATURE