Vivian Medina, D.D.S.
3630 Madaca Lane · Tampa, FL 33618
Office: (813) 264-0286 · Fax: (813) 960-4667

Patient Information: Preferred Name ______________________________ Today's Date ____/____/____

Last Name ___________________ ___ First Name _____________________ Middle Initial ______ Birth Date ____/____/_____

Social Security # ________________________ Check Appropriate Boxes: ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married

Address ____Apt # ________ City ________________ State_____ Zip_________

Home Phone _____________________ Cell Phone _____________________ E-Mail _______________________________________

Preferred Method of Contact between 8:00 a.m. & 5:00 p.m.: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-Mail

Preferred language spoken: ____________________

{If minor, please provide name of Guardian, as well as contact information.}

Last Name ___________________ ___ First Name _____________________ Middle Initial ______ Relationship _____________

Address ____Apt # ________ City ________________ State_____ Zip_________

Best Phone __________________________ Birth Date _____/_____/______ Social Security # _____________________________

Patient's Employer / School:

If Student, Name of School/College ____ ☐ Full time ☐ Part Time

Patient's or Parent's Employer ____ Work Phone _____________________

Responsible Party:

Name of Person Responsible for Account _____________________________________ Relationship to Patient __________________

Driver's License #____________________ State _____ Birth Date ____/____/_____ Social Security # ______________________

Dental Insurance Co. ____ Insurance Co. Phone _________________________

Policy Holder's Name ___________________________________ Member ID #_____________________ Group # ______________

Social Security # ________________________ Birth Date _____/_____/______ Relationship to Patient _____________________

Additional Information:

Emergency Contact Name ____ Phone _____________________________

Whom may we thank for referring you to our office? ____

Our Policies & Practices:

Policies: I have read and understand Dr. Vivian Medina's office policies. Please initial: _________________

Insurance Assignment & Release: I authorize this office to release any information necessary to expedite insurance claims. I authorize use of signatures on this form for insurance claim submissions. I authorize and assign all insurance payments directly to Vivian Medina, D.D.S. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent or Guardian signature: ____ Date: ______/______/______

HIPAA Compliance Acknowledgement of Receipt: I acknowledge that I have received a copy of this office's NOTICE OF PRIVACY PRACTICES and I hereby consent to the use and disclosure of my personal health information by your office for Treatment, Billing/Payment and Healthcare Operations as outlined in the NOTICE OF PRIVACY PRACTICES. Please allow access to all my patient records and information to: Name & Relationship ____

Patient, Parent or Guardian signature: ____ Date: ______/______/______

Vivian Medina D.D.S
Dental History

Do you have a specific dental problem? **YES NO** *If yes please describe*___________________

Do you have regular dental care? **YES NO** Last visit: _______________________________

Do you floss? **YES NO** How often? _________________________

Name of previous Dentist (if applicable)____

Last date of X-rays__________________ *Panorex* *Bitewings* *Full series*

SYMPTONS *circle all that apply*

Headaches	Facial Pain	Difficult Swallowing
TMJ pain/Noise	Sensitive Teeth	Loose tooth
Limited Opening	Difficulty Chewing	Clenching
Ear Congestion	Neck Pain	Hot/Cold Sensitivity
Dizziness	Postural Problems	Insomnia
Ringing In Ears	Tingling In Fingers	Back Pain
Bell’s Palsy	Trigeminal Neuralgia	Snoring

MEDICAL HISTORY *circle all that apply*

Heart Murmur	Artificial Joint Replacement	Blood Disease
Angina/Chest Pain	Pins	Bleeds Easily
Heart Attack/Failure	Asthma	HIV/AIDS
Congenital Heart Disease	Sinus Problems	Hepatitis (A,B, or C)
Mitral Valve Prolapse	Lung Disease	Venereal Disease
Rheumatic Fever	Kidney Disease	Cancer
Heart Pace Maker	Liver Disease	Thyroid Problems
Artificial Heart Valve	Diabetes	Tuberculosis
Irregular Blood Pressure	Fever Blister/Cold Sore	Allergies

Other?____

Are you allergic to any medications? **YES NO** *if yes, please explain the reaction*____

Do you use recreational drugs? **YES NO** *If yes, please explain*________________________

Do you smoke of chew tobacco? **YES NO** *If yes, please explain* ________________________

Are you under a physician’s care? **YES NO** *if yes, please explain*_________________________

Are you taking any medications? **YES NO** *If yes, please explain*_________________________

Are you taking any supplements? **YES NO** *If yes, please explain*_________________________

Are you taking any over the counter medications?_______________________________________

Have you had an adverse reaction to local anesthetic? **YES NO**

*If yes, please explain*____

Are you pregnant? **YES NO** Normal Blood Pressure___________________________

Have you ever been diagnosed with sleep apnea? **Yes No**

X____ **Date**__________________

Vivian Medina, D.D.S

My Personal Smile Evaluation

When I see a picture of myself…

____ I wish my teeth were whiter.

____ I wish I had a wider, broader smile.

____ My teeth have rough edges.

____ My gums show too much [ ]or not enough [ ] when I smile.

____ My top teeth don't show enough.

____ I have discolored areas between my teeth.

____ There is too much space between some of my teeth.

____ I am not totally pleased with my smile.

____I am interested in options available for enhancing my smile.

____ I am completely satisfied with my smile.

____I would like to be provided with more information regarding surgical and cosmetic procedures.

My teeth are: ____ crowded ____ uneven

____ crooked ____ overlapped