Welcome to Boca Dental Arts

Today's Date:___________________

21073 Powerline Rd, Ste 65
Boca Raton FL 33433
(561) 235-5424

Patient's name: Date of birth:

Mailing address:

Telephone:

Emergency contact / telephone number:

Dental Information

Please check if:	yes	no
your gums bleed when you brush or floss		
your teeth are sensitive to cold, hot, sweet, or pressure		
you have had periodontal (gum) treatment		
your mouth is dry		
you wear partials or dentures		

Please check if:	yes	no
you have ear aches or neck pains		
you have clicking, popping, or discomfort in the jaw		
you brux or grind your teeth		
you have sores or ulcers in your mouth		
you had any problems associated with previous dental treatment		

Name of your last treating dentist: Date of last radiographs:

What was done at your last visit?

How do you feel about your smile?

The reason for your visit today?

Please check if you are allergic to or had reaction to:	yes	no
local anesthetic ("novocain")		
penicillin or other antibiotics		
barbiturates, sedatives, sleeping pills		
sulfa drugs		
codeine or other narcotics		
metals		

Please check if you are allergic to or had reaction to:	yes	no
latex (rubber)		
iodine		
animals		
food		
hay fever /seasonal		
other		

Please check if you have/had these conditions requiring Pre-Medication:	yes	no
artificial (prosthetic) heart valve		
previous infective endocarditis		
congenital heart disease (CHD)		

Medical Information

Please check if you have/had:	yes	no
Allergies, Hay Fever		
Anemia		
Arthritis, Rheumatism		
Artificial heart valve		
Artificial joints		
Asthma		
Asthma, with Steroids		
Bleeding abnormally with surgery		
Blood disease, clotting disorders		
Cancer		
Chemotherapy, Radiation		
Circulatory problems		
Congestive heart defect		
Cortisone treatment		
Diabetes (Type:)		
Eating disorder		
Emphysema		
Epilepsy		
Fainting		
Gastrointestinal disease/Reflux/Heartburn		
Glaucoma		
Headaches		
Heat murmur		
Heart attack/Heart problems		
Heart valve damage		
Hepatitis (Type:)		
Herpes		

Please check if you have/had:	yes	no
Hemophilia		
High blood pressure		
Low blood pressure		
Immune deficiency (HIV/AIDS)		
Kidney disease		
Mental health disorders		
Mitral valve prolapses		
Osteoporosis		
Pacemaker		
Respiratory disease		
Scarlet fever		
Sexually transmitted disease		
Shortness of breath		
Sinus trouble		
Sickle cell anemia		
Skin rash		
Stroke		
Thyroid problems		
Tonsillitis		
Tuberculosis		
Tumor or growths on head/neck		
Ulcer		
Smoke – cigarettes, pipe, cigars		
Use smokeless tobacco		
Consume alcoholic beverages		
Use controlled substances		
Pregnant, Nursing		

Your physician's name: Date of last physical:

Please list all prescription and over the counter medications, including vitamins, herbal preparations, and dietary supplements:

Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment. You certify that you have read and understand the above and that the information given on this form is accurate. You understand the importance of a truthful Heath History and that Dr. McGuffie and his staff will rely on this information for treating you. You acknowledge that your questions, if any, about inquires set forth above have been answered to your satisfaction. You will not hold Dr. McGuffie, or any member of his staff, responsible for any action they take or do not take because of errors or omissions that you may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient/Legal Guardian: Date:

People with Whom This Office May Discuss Your Healthcare

Boca Dental Arts

21073 Powerline Rd, Ste 65
Boca Raton FL 33433
(561) 235-5424

Print Patient's Name: ______________________________

Patient's Signature: ______________________________

Date: ______________________

Please print name and relationship of each person with whom we can discuss your healthcare.

Name: ______________________________

Relationship: ______________________________

Name: ______________________________

Relationship: ______________________________

Name: ______________________________

Relationship: ______________________________

Name: ______________________________

Relationship: ______________________________