Joseph E. Pechter, D.M.D.

Specializing in Periodontics and Dental Implants

4350 Sheridan Street, Suite 201D, Hollywood, FL 33021

Personal Information:

Name: ______________________________ Date: ______________

Address: ____
Street City State Zip

Home Phone: ____________________ Birth Date: ____________________

Cell Phone: ____________________Soc.Sec.#: ____________________

Work Phone: ____________________ Employer: ____________________

Email: ____________________ Referred by: ____________________

Emergency Contact: ____________________ Phone: ____________________

Dental Insurance: If you have insurance through Delta Dental or through Memorial Hospital, we will be happy to accept assignment of benefits, meaning we will wait for your insurance to pay us and we will ask that you pay only your estimated co-pay at the time of treatment. If you have insurance through any other carriers, we will ask that you pay for your services in full at the time of treatment. We will be happy to file your insurance claims for you and ask that your insurance carrier send payment directly to you. If you have questions about your insurance benefits, we will be happy to work with you and your insurance company to answer your questions.

Carrier Name: ______________________________Phone: ____________________

Subscriber Name: ______________________________ Subscriber ID: ______________

Subscriber Birth Date: ______________ Group Name/Number: ______________

Health History:

Physician's Name: ____________________ Phone: ____________________

Are you currently under a physician's care? □YES □NO Last Exam: ______________

Are you currently taking any medications? □ YES □NO If YES, please list below:

____

Are you taking any blood thinner or aspirin? □YES □NO If YES, please list below:

____

Are you or have you ever taken a bisphosphonate like Fosamax or Actonel?□YES □ NO

Are you allergic to or have you had a reaction to any of the following? Check all that apply:

Local Anesthetics	Aspirin	Penicillin
Sulfa Drugs	Iodine	Latex
Codeine/Narcotics	Any Metals	Other

Do you have or have you had any of the following conditions? Check all that apply:

Rheumatic Fever	Blood Transfusion	Kidney Disease
Congenital Heart Defect	Hepatitis/Liver Disease	Anemia
Heart Valve Replacement	Hip/Knee Replacement	Cancer/Chemo/Radiation
Heart Attack/Stroke	Diabetes	Sinus Problems
AIDS or HIV Infection	High Blood Pressure	Gastroinstetinal Disease
Hemophilia	Low Blood Pressure	Herpes
Heart Murmur/MVP	Tuberculosis (TB)	Dry Mouth
Thyroid Problems	Osteoporosis	Other

Has a physician recommended that you take antibiotics prior to dental treatment? □YES □NO

Have you ever had a serious illness or surgery? □YES □NO

If YES, please explain: ______________________________

Are there any conditions, or problem not listed above that we should be aware of?□YES □NO

If YES, please explain: ______________________________

Do your gums bleed when you brush or floss? □YES □NO

Have you had periodontal (gum) treatments in the past? □YES □NO

Have you had orthodontic (braces) treatment? □YES □NO

Do you have any clicking, popping, or discomfort in the jaw? □YES □NO

Do you grind your teeth? □YES □NO

Have you had an injury to the face?□YES □NO

Do you wear dentures or partials? □YES □NO

Do you use tobacco: cigarettes, cigars, pipes, or chewing tobacco? □YES □NO

Date of last dental exam: ______________ Last cleaning: ______________

Reason for today's visit? ______________________________

The above information is accurate and correct to the best of my knowledge.

Patient/Guardian Signature ______________________ Date: ______________

Reviewed by: ______________________ Updated on: ______________