Joseph E. Pechter, D.M.D.

Specializing in Periodontics and Dental Implants
2699 Stirling Rd. Suite C201, Hollywood, FL 33312

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: _____