James L. Carazola, D.M.D., P.A.
Periodontics and Implants
3003 Enterprise Road East · Clearwater, FL 33759
P: (727) 799-4492 · F: (727) 724-8963

PATIENT INFORMATION

Name		I prefer to be called	
Home Phone		Office	Cell
Home Address			
Email		Preferred Contact ☐ Email ☐ Work ☐ Cell ☐ Home	
Birth Date	Marital Status:	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other ☐ Minor	
Age	Social Security #	Employer	Occupation
Spouse's or Guardian's Name		Spouse's or Guardian's Employer	
Emergency Contact		Phone	
Physician		Phone	Last Physical
Dentist		Phone	Years
Referred By		Phone	
Who is financially responsible for this bill?			
Drivers License #			

I request and consent to treatment as necessary or desirable to the care of the patient first named above, including whatever medications, performance, of operations and laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate. I also certify that the information provided is true and accurate.

Signature_____ Date_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company	
Group #	Phone
Subscriber	Subscriber's Date of Birth:
ID #	
Employer	

Secondary Dental Insurance

Insurance Company	
Group #	Phone
Subscriber	Subscriber's Date of Birth:
ID #	
Employer	

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MEDICAL AND DENTAL HISTORY

HAVE YOU HAD...	YES	NO
Hepatitis or Liver Disease		
Epilepsy/Seizures		
Rheumatic Fever		
Kidney Disease		
Diabetes		
Tuberculosis		
Heart Trouble		
Damage Heart Valves		
Mitral Valve Prolapse (MVP)		
Artificial Heart Valves		
Heart Transplant		
History of Endocarditis		
*Stent - **Year Placed?**:*		
Arteriosclerosis		
Stroke		
Cardiac Pacemaker		
Heart Murmur		
High/Low Blood Pressure		
Shortness of Breath		
Chest Pains		
Allergies		
Medical Treatment by Radiation		
Venereal Disease		
Surgery		
Glaucoma		
Prostate Trouble		
Contact Lenses		
Psychiatric Treatment		
Burning Tongue		
Ulcer		
Sinus Problems		
Asthma		
Treatment for a Tumor/Growth		
a Blood Transfusion		
*a Prosthetic Replacement (hip, knee, etc..) **Year Placed:***		
a Drug Reaction		
Any reaction to Aspirin		
Any reaction to Barbiturates		
Any reaction to Anesthetics		
Any reaction to Penicillin		

	YES	NO
Any reaction to Sulfa Drugs?		
Allergy to Latex?		

Any other medication allergies?

Do any family members have diabetes?
☐ YES ☐ NO If YES, Please List with age first diagnosed:

FEMALES		
Are you pregnant?		
Taking anti-pregnancy drug?		
Presently in menopause?		
Past menopause?		
Taking osteoporosis drugs ☐ now or ☐ ever?		

HAVE YOU OR ARE YOU TAKING	YES	NO
Anticoagulants?		
Bisphosphonates (osteoporosis)?		
Cortisone?		
Tranquilizers?		
Nitroglycerin?		
Penicillin?		
Aspirin Daily?		
Digitalis, heart medicine?		
High Blood Pressure Medication		

Other(s)? *Please include list*

ARE YOU OR DO YOU...	YES	NO
Under the care of a physician?		
easily exhausted or fatigued?		
slow in healing?		
in good health now?		
aware of grinding or clenching your teeth day or night?		
Have sore teeth?		
Have swollen ankles?		
Have prolonged bleeding after injury or extraction?		

	YES	NO
Allergic to dental anesthetic?		
Frequent urination?		
Are you *often thirsty?*		
Do you have *frequent headaches?*		
Have a persistent cough or cough up blood?		
Are you *short of breath when you lie down?*		
Do you *require extra pillows when you lay down?*		
Do you *have a blood disorder?*		
Have you used tobacco? ☐ *Now* ☐ *Never* ☐ *Previous*		
Have you *used drugs?*		
Have you *used alcohol?*		
Pencil chewing habit?		
Fingernail biting habit?		
Pipe smoking habit?		
Do you *have unpleasant tastes in your mouth?*		
Do you *have bad breath?*		
Do you *have bleeding gums?*		
Tooth sensitivity? ☐ *Heat* ☐ *Cold* ☐ *Sweets*		
Do you *pre-medicate?*		
Do you *use dental floss?*		
Do you *have a fear of dental treatment?*		

Do you want to keep your teeth?
☐ YES ☐ NO
☐ *No matter how much trouble*
☐ *If it's not too much trouble*
☐ *Don't care* ☐ *Don't know*

Do you have any serious illness not listed? If Yes, please list.

Have you been diganosed for
☐ *HIV* ☐ *AIDS* ☐ *TUBERCULOSIS/TB*

Signature_____

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PERIODONTICS and IMPLANTS

(727) 799-4492

NAME: _____ DATE: _____

Do you take or ever have taken in the past: *Fosamax, Actonel, Boniva, Atelvia, Aredia, Zometa, Reclast*?

Theses drugs are used in the treatment of Osteoporosis. They are part of a family of drugs called Bisphosphonates.

YES_____ NO_____

If yes, please give dates and amounts:

_____

_____

Do you take ASPIRIN daily?_____ VITAMIN E daily?_____

FISH OIL daily?_____ FLAX SEED daily? _____

Have you had any joint replacements? (hip, knee, etc…) _____ Date _____

Have you been diagnosed with a heart condition, heart murmur, or Mitral Valve Prolapse?

_____ if yes, are you required to take antibiotics prior to a dental visit?_____

Have you had recent treatment for cancer?_____ If so, are you cleared for

dental cleanings/surgeries?_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice and that you have read the email release. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

E-MAIL RELEASE FORM

I, _____ I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail.

I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail. I also understand that any Confidential Health Information of mine may be sent to my general dentist or a specialist. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

Name: _____

(Print Patient's Name or Name of Patient's Representative)

Signature: _____