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 / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient Legal Relationship to the Patient
(*If required*)

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone_____

2. Name _____ Relationship _____ Phone_____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____. Please initial _____.

Or

_____ I decline to receive communications via **text**.

_____ I decline to receive communications via **email**.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible

This form does not constitute legal advice and covers only federal, not state, law.