Palm City Dentistry
Dr. Rene Aviles DMD, PA

Date_____

Please circle: Male or Female ___Married ___Single ___Other

First Name_____ Last Name_____

Address_____ City_____Zip_____

Patients SSN# _____ DOB: _____/_____/_____ Email: _____

Home # _____ Cell Phone# _____ Work#_____

Reason for visit_____ Referred by: _____

Employer: _____ Occupation: _____

INSURANCE INFORMATION

Insurance Carrier: _____ Group# _____

Subscriber's Name: _____ Subscriber's Employer: _____

Subscriber ID or SSN#_____ Subscriber's DOB: _____/_____/_____

Name of Physician: _____ Phone _____

Health History

Are you allergic to any medication(s)? YES / NO if yes, which one(s)_____
Did you Pre-Medicate with antibiotics for this visit? YES/ NO If yes, Name of antibiotic_____
Are you pregnant? YES / NO Are you taking birth control medications? YES / NO
Are you taking Bisphosphonates? (Medication for your bones) YES/ NO

Please list all of your current medications on next line:

_____
_____

Have you had any of the following? If so, please circle and provide the date:

Heart Attack	Diabetes	Hyperthyroidism
Heart Condition	Glaucoma	Hypothyroidism
Heart Murmur	Respiratory Condition	AIDS
Heart Pace Maker	Emphysema	Drug/Alcohol addict
Heart Surgery	Asthma	STD
Heart Defibrillator	Tuberculosis	Cancer
Congenital Heart Lesions	Hepatitis	Chemotherapy
High Blood Pressure	Sickle Cell Disease	Radiation Therapy
Low Blood Pressure	Anemia	Psychiatric Treatment
Artificial Heart Valve	Hemophilia	Epilepsy/ Seizures
Rheumatic Fever	Leukemia	Strokes
Scarlet Fever	Yellow Jaundice	Arthritis
Artificial Joints/Knee/Hip	Liver Disease	Rheumatism
Stomach Ulcers	Sinus Problems	SMOKER

Any other condition not listed? _____

Patient or Guardian Signature: _____

Doctors Signature: _____