



RENÉ F. CEDEÑO
D.M.D.

RESTORATIVE & COSMETIC DENTISTRY
305.598.4885 | 8200SW 117TH AVE | SUITE 408. MIAMI, FL 33183
info@rcdentalconcepets.com

ADULT PATIENT REGISTRATION

Date _____

PATIENT INFORMATION

Patient Name _____

Address _____
City State Zip

Home # _____

Work # _____

Sex: M F Single Married

D.O.B. _____

Social Security # _____

Email Address _____

Occupation _____

Employer _____

Employer Address _____

Spouse Name _____

D.O.B. _____

Whom may we thank for referring you?

DENTAL INSURANCE

INSURANCE COMPANY _____

SUBSCRIBER'S NAME _____

ID # _____ GROUP # _____

PHONE # _____

ADDRESS _____

MEDICAL INSURANCE

INSURANCE COMPANY _____

SUBSCRIBER'S NAME _____

ID # _____ GROUP # _____

PHONE # _____

ADDRESS _____

AUTHORIZATION

I authorize the assignment of benefits to Dr. Cedeño from the insurance company for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure the payment of benefits.

Responsible Signature

Date

IN CASE OF EMERGENCY, CONTACT:

Name _____

Phone # _____

Relationship _____

DENTAL / MEDICAL HISTORY

Reason for today's visit _____

Date of last dental visit _____ Date of last dental x-rays _____

How do you feel about the appearance of your teeth? _____

Please Mark Yes (Y) or No (N) if you have had any of the following:

Y N Acid Reflex

Y N Anxiety

Y N Bad Breath

Y N Bleeding Gums

Y N Blisters On Lips Or Mouth

Y N Bruxism

Y N Burning Sensation On Tongue

Y N Chapped Lips

Y N Chew On One Side Of Mouth

Y N Smoking

Y N Clicking Or Popping Jaw

Y N Chronic Pain

Y N Do you use a CPAP Machine?

Y N Dry Mouth

Y N Grinding Teeth

Y N Gums Swollen Or Tender

Y N Insomnia

Y N Jaw Pain Or Tiredness

Y N Loose Teeth Or Fillings

Y N Mouth Breathing

Y N Mouth Pain

Y N Sleep Apnea (Family History)

Y N Snore

Y N Sores Or Growths In Mouth

Y N Tobacco Use

Y N Trouble Falling/Staying Asleep

MEDICAL HISTORY

Physicians Name _____ Date of Last Visit _____

Please mark Yes or No if you have had any of the following:

YES	NO	Aids/HIV	YES	NO	Epilepsy	YES	NO	Shortness of Breath
YES	NO	Alzheimer's/Dementia	YES	NO	Fainting or Dizziness	YES	NO	Sinus Trouble
YES	NO	Anemia	YES	NO	Glaucoma	YES	NO	Steroid Hormone Therapy
YES	NO	Arthritis	YES	NO	Headaches	YES	NO	Stroke
YES	NO	Artificial Joints				YES	NO	Swelling of Feet / Ankles
YES	NO	Asthma	YES	NO	Heart Problems	YES	NO	Swelling of Neck Glands
YES	NO	Blood Clots	YES	NO	Cardiac Bypass Surgery	YES	NO	Thyroid Problems
YES	NO	Bleeding Abnormality	YES	NO	Cardiac Pacemaker	YES	NO	Tonsillitis
		With Extractions/ or Surgery	YES	NO	Congenital Heart Defects	YES	NO	Tuberculosis
			YES	NO	Heart Attack	YES	NO	Tumors or Growths
YES	NO	Blood Disease	YES	NO	Heart Murmur	YES	NO	Ulcer
YES	NO	Cancer	YES	NO	Mitral Valve Prolapse	YES	NO	Venereal Disease
YES	NO	Chemotherapy	YES	NO	Prosthetic Valve Surgery	YES	NO	Weight Loss / Gain Unexplained
YES	NO	Cholesterol						
YES	NO	Circulatory Problems	YES	NO	Hepatitis Type _____			
YES	NO	Cortisone Treatments	YES	NO	Herpes			
YES	NO	Cough, Persistent or Bloody	YES	NO	High Blood Pressure			
			YES	NO	Jaundice			
YES	NO	COVID-19	YES	NO	Kidney Disease			
YES	NO	Defibrillator	YES	NO	Liver Disease			
YES	NO	Depression	YES	NO	Low Blood Pressure			
YES	NO	Diabetes	YES	NO	Lung Disease			
YES	NO	Emphysema	YES	NO	Nervous Problems			

FOR WOMEN:

YES NO Are you pregnant?
YES NO Taking Birth Control?
YES NO Due Date _____
YES NO Nursing

Is there anything else we should know about that is not listed? Yes No

If yes, explain: _____

YES NO Are you taking any **blood thinner medication**, such as Plavix, Coumadin, Warfarin, Eliquis, etc?
YES NO Are you taking any **osteoporosis medication**, such as Boniva, Fosamax, Prolia, etc?
YES NO Do you experience any daytime tiredness?
YES NO Do you experience head, neck, or jaw pain?
YES NO Do you wake up feeling rested?
YES NO Have you taken a sleep test?
YES NO Have you used Botox / Derma fillers?

If yes, please list medication: _____

MEDICATIONS

List of medications you are currently taking:

Pharmacy Name _____

Phone # _____

ALLERGIES

Check all that apply:

ASPIRIN	LOCAL ANESTHETIC
ACRYLIC	LATEX
CODEINE	METAL
IODINE	PENICILLIN
SULFA	OTHER _____

Reviewed by _____

Date _____