Name: ____________ ____ ______________ ________________ ______________

first **mi** **last** **date of birth** **today's date**

1 *Adult Patient Information*

Do you have a preferred name?____________________

Which months do you reside in Florida?____________________

Local address:______________________________
street & no. bldg. apt #

____
city state zip

Local telephone: home______________cell______________

alternate telephone:______________________

Do you reside in an adult care facility? ☐ Yes ☐ No

Facility name______________________________

Facility address______________________________

Facility telephone______________Contact person______________

May we text you to confirm appointments? ☐ Yes ☐ No

Occupation:______________Employer:______________

Business telephone:______________________

Spouse/Significant other/Caregiver name:______________

Who to call in case of emergency:______________

relation______________phone______________

Referred by:______________________________

2 *Child Patient Information*

Note: The adult bringing the child in for the appointment is considered financially responsible.

Child's nickname:______________________________

Child's birthday:____________________Age__________

School:____________________Grade__________

Child's local address:______________________________
street & no.

____
city state zip

Parent / Guardian name:______________________

Address:______________________________

Telephone #'s______________________________
home work cell

Pediatrician:______________________________

Phone:______________________________

Are there any medical conditions your child has that we should be aware of ?:______________________

Note: Please be sure to answer questions on the Medical History of this form.

3 *Medical History*

Physician (s) name (s)______________________________Telephone______________

Do you / have you ever had to Premedicate for dental appointments? ☐ Yes ☐ No

***Reason for Premedication*:**______________________________

Do you have a Pacemaker? ☐ Yes ☐ No Are you taking blood thinners (Coumadin/Aspirin)? ☐ Yes ☐ No

List all medications you are taking:______________________________

____

Do you have or have you had any of the following diseases, medical conditions or procedures? (circle all that apply)

Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Rheumatic Fever
Y N Mitral Valve Prolapse
Y N Artificial Valves / Heart Stent
Y N Heart Disease
Y N Congenital Heart Defect
Y N Thyroid Problems
Y N Kidney Problems
Y N Liver Problems
Y N Respiratory Problems
Y N Sinus Problems
Y N Stomach Problems / Ulcers
Y N Alcohol / Drug Abuse
Y N Tuberculosis
Y N Cancer / Tumors
Y N Hepatitis
Y N Arthritis / Rheumatism
Y N Artificial Bones / Joints
Y N Severe / Frequent Headaches
Y N Epilepsy / Seizures
Y N Chemotherapy / Radiation Therapy
Y N Asthma / Hay Fever
Y N Diabetes / Hypoglycemia
Y N High / Low Blood Pressure
Y N Bleeding Problems
Y N Stroke
Y N Vertigo
Y N Impaired vision or hearing

Please list any other medical condition (s) you have or ever had:______________________________

Are you allergic to or had any adverse reaction to any of the following? ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Aspirin ☐ Barbituates / Sedatives ☐ Latex ☐ Other Drugs______________

Do you use tobacco products? ☐ Y ☐ N How often______________for how long?______________

For women: Are you Pregnant? ☐ Y ☐ N Month________ Are you nursing? ☐ Y ☐ N

Please turn over to continue

4 Dental Information

Reason for today's visit:________________________________

Are you in pain? ☐ Yes ☐ No How long________________Symptoms________________

Please indicate any of the following problems: by placing ✓ mark in boxes that apply

☐ Discomfort, clicking or popping in jaw

☐ Red, swollen, or bleeding gums

☐ Sensitive teeth or gums

☐ Stained / dark teeth

☐ Broken / chipped teeth

☐ Grinding / clenching

Previous dentist name & location________________________________

Last dental exam________________last dental radiographs / xrays________________

Is there anything you do not like or would like to change about your teeth / smile?________________

Do you have any missing teeth? ☐ Yes ☐ No

Would you like your teeth to be whiter? ☐ Yes ☐ No

Have you had Orthodontia (Braces)? ☐ Yes ☐ No

Orthodontist's name________________

5 Account Information

Person ultimately responsible for payment

(This name will appear on billing statements)

Name:________________________________

Full mailing address:________________________________

City________________State_____Zip________

Social Security #:________________DOB:________

Home phone:____________Work phone:____________

Cell:________________________________

♦ **Payment for services are Due at time of treatment.**

♦ A fee is assessed to all accounts for any NSF / Returned checks.

♦ Without the courtesy of 24 hours notice there will be a charge for reserved appointments **Broken or Cancelled.**

♦ I acknowledge and agree with the above office policies.

____

date signature

6 Insurance Information

Primary Dental Insurance

Insurance Company name:________________________________

Address________________________________

City State Zip

Phone # carrier:________________________________

Insured's SS# or ID #:________________________________

Group Plan / Policy #:________________________________

Insured's name:________________________________

Date of birth:___/___/____Relationship:________________

Insured's employer:________________________________

♦ We do not accept assignment of benefits.

♦ **Payment for services are due at the time of treatment.**

♦ As a courtesy, we will file your claim with your Primary Insurance.

♦ Reimbursement of covered services will come to you from your Insurance Provider.

♦ I authorize the provider to release any information required to process my insurance claims on my behalf.

____

date signature subscriber or authorized person

7

♦ I authorize the office to use pictures of my teeth for educational purposes: Yes____________No________
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♦ We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between our office and you, the patient.

♦ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred as a result of collection efforts on your account.

♦ I authorize the staff to perform any necessary services needed during diagnosis and treatment, under the dentist's supervision.

♦ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:________________________________Date:________________

patient or legal guardian / responsible party