WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible health care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____

Birthdate _____

Soc. Sec. #_____ E-mail _____

Name _____

Wishes to be called _____

Male Female Minor Single Married Divorced Widowed Separated

Address _____

City_____ State_____ Zip _____

Employer _____ Occupation _____

Who may we thank for referring you? _____

2 Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Is this person currently a patient in our office Yes No

Birthdate_____ Driver's License # _____

Soc. Sec. #_____ **E-mail** _____

Address _____

City_____ State_____ Zip _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone_____ Cell Phone_____

3 Telephone

Home Phone _____

Work Phone _____ Ext. # _____

Cell Phone _____

Where do you prefer to receive calls? Home Work Car

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name_____ Relationship_____ Work #_____ Home #_____

4 Insurance Information

Primary Dental Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

Soc. Sec. # _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

5 24-Hour Cancellation

IMPORTANT: If you cannot keep your appointment, please provide at least 24 hours advance notice or you may be charged a cancellation fee.

Signature _____

6 Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)

7 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card ____ Visa ____ MC

_____ Finance Plan (Upon Approval)

I authorize the dental staff to perform the necessary dental services, that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

FORM 006321 R/04/08 ITEM 8101

Health History

NAME_____ BIRTHDATE_____ TODAY'S DATE_____

A Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Previous Dentist_____

Phone _____

	YES	NO
1. Are you in good health?	☐	☐
2. Have there been any changes in your general health within the past year?	☐	☐
3. Date of your last physical exam: _____		
4. Physician's name _____ Address _____ Phone No. _____		
5. Are you now under the care of a physician?	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. _____	☐	☐
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? _____	☐	☐
8. Have you ever taken Fen-Phen/Redux?	☐	☐

	YES	NO
9. Have you had any abnormal bleeding?	☐	☐
10. Do you bruise easily?	☐	☐
11. Have you ever required a blood transfusion?	☐	☐
12. Have you had a recent weight loss?	☐	☐
13. Do you have a persistant cough or throat clearing not associated with a known illness (lasting more than 3 weeks?)	☐	☐
14. Do you use tobacco?	☐	☐
15. Do you use alcohol? How often _____	☐	☐
16. Do you use recreational drugs?	☐	☐
17. Are you wearing contact lenses?	☐	☐
18. Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐

Women Only:

1. Are you pregnant or think you may be pregnant?	☐	☐
2. Are you nursing?	☐	☐
3. Are you taking birth control pills?	☐	☐

Are you allergic to or have you had reactions to:	YES	NO
1. Local anesthetics like novocaine?	☐	☐
2. Penicillin?	☐	☐
3. Other Antibiotics	☐	☐
4. Sulfa drugs?	☐	☐
5. Barbiturates, sedatives or sleeping pills?	☐	☐
6. Aspirin?	☐	☐
7. Iodine?	☐	☐
8. Metals	☐	☐
9. Latex Gloves	☐	☐
10. Other? _____	☐	☐
Do you have or have you ever had the following:		
1. Rheumatic heart disease or rheumatic fever?	☐	☐
2. Scarlet fever?	☐	☐
3. Heart defect or heart murmur, mitral valve prolapse (MVP)?	☐	☐
4. Heart trouble, heart attack, or angina?	☐	☐
a. Do you have pain in your chest upon exertion?	☐	☐
b. Are you ever short of breath after mild exercise?	☐	☐
c. Do your ankles swell?	☐	☐
d. Do you get short of breath when you lie down?	☐	☐
e. Do you require extra pillows when you sleep?	☐	☐
5. Pacemaker?	☐	☐
6. Heart surgery?	☐	☐
7. High blood pressure?	☐	☐
8. Low blood pressure?	☐	☐
9. Hepatitis, jaundice or liver disease?	☐	☐

	YES	NO
10. Stroke?	☐	☐
11. Sinus trouble?	☐	☐
12. Lung or breathing problems?	☐	☐
13. Asthma or hay fever?	☐	☐
14. Allergies?	☐	☐
15. Hives or skin rash?	☐	☐
16. Fainting spells or seizures?	☐	☐
17. Tuberculosis?	☐	☐
18. Persistent cough?	☐	☐
19. Cough that produces blood?	☐	☐
20. Diabetes?	☐	☐
21. Epilepsy?	☐	☐
22. Anemia?	☐	☐
23. Cancer?	☐	☐
24. Leukemia?	☐	☐
25. Glaucoma?	☐	☐
26. Recent Weight Loss?	☐	☐
27. Radiation Therapy?	☐	☐
28. Thyroid problems?	☐	☐
29. Arthritis or rheumatism?	☐	☐
30. Joint replacement or implant?	☐	☐
31. Stomach ulcer?	☐	☐
32. Kidney trouble?	☐	☐
33. Emphysema?	☐	☐
34. AIDS or HIV infection?	☐	☐
35. Sexually transmitted disease?	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

(OVER)

DATE

B Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ❒ Soft ❒ Medium ❒ Hard

	YES	NO
5. Do your gums bleed while brushing?	❒	❒
6. Do your gums bleed when flossing?	❒	❒
7. Do you feel pain to any of your teeth when brushing or flossing them?	❒	❒
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	❒	❒
9. Have you noticed any loosening of your teeth?	❒	❒
10. Does food tend to become caught between your teeth?	❒	❒
11. Do you have any sores or lumps in or near your mouth?	❒	❒
12. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	❒	❒
b. Pain (joint, ear, side of face)?	❒	❒
c. Difficulty in opening or closing?	❒	❒
d. Difficulty in chewing?	❒	❒

	YES	NO
13. Have you had any head, neck, or jaw injuries?	❒	❒
14. Do you have frequent headaches?	❒	❒
15. Do you clench or grind your teeth while awake or asleep?	❒	❒
16. Do you bite your lips or cheeks frequently?	❒	❒
17. Have you ever had:		
a. Orthodontic treatment (braces)?	❒	❒
b. Oral surgery?	❒	❒
c. Gum treatment?	❒	❒
d. Your teeth ground or the bite adjusted?	❒	❒
e. Worn a bite plane or other appliance?	❒	❒
18. Are you satisfied with the appearance of your teeth?	❒	❒
19. Have you ever had an upsetting experience in the dental office?	❒	❒
20. Is there anything about having dental treatment that bothers you?	❒	❒

Signature _____

For Completion By The Dentist:

DOCTOR'S COMMENTS:

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	INITIALS: PATIENT	DENTIST	HYGIENIST

PATIENT CONSENT FORM

Dr. Brian Decker
Dr. Ann M. Pomeranz
7575 W. University Avenue
Suite P
Gainesville, Florida 32607

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20 ____ .

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

FORM 143306 R/08/09 ITEM 8101