Tarpon Shores DENTAL

CHART # _____

REGISTRATION

First Name _____ Last Name _____ Middle Initial _____ Preferred Name _____

Address _____ City / State / Zip _____

Home Phone _____ Work Phone _____ Ext. _____ Cell _____

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date _____ Age _____ Soc. Sec. _____ Spouse Name _____

E-mail _____ ☐ I would like to receive correspondences via e-mail.

Employment Status ☐ Full Time ☐ Part Time ☐ Retired Profession _____

Current Status ☐ High School ☐ College Other _____

Do you have an out of town address? ☐ Yes ☐ No If yes, please list months away _____

Out of town City and State _____ Phone # _____

Who will pay this account? _____ Do you have insurance that may cover any part of our professional services? ☐ Yes ☐ No

Whom may we thank for referring you? _____

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 you will receive. Thank you for answering the following questions.

Are you allergic to any of the following? ☐ Yes ☐ No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics (Dental) ☐ Other _____

Women are you

☐ Taking oral contraceptives? ☐ Pregnant/Trying to get pregnant? ☐ Nursing?

OFFICE USE ONLY

Do you have, or have you had, any of the following? ☐ Yes ☐ No

☐ AIDS/HIV Positive	☐ Cancer	☐ Excessive Thirst	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Stomach/GI Disease
☐ Alzheimer's Disease	☐ Chemotherapy	☐ Fainting Spells/Dizziness	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Stroke
☐ Anaphylaxis	☐ Chest Pains	☐ Frequent Cough	☐ Herpes	☐ Psychiatric Care	☐ Swelling of Limbs
☐ Anemia	☐ Cold Sores/Fever Blisters	☐ Frequent Diarrhea	☐ High Blood Pressure	☐ Radiation Treatments	☐ Thyroid Disease
☐ Angina	☐ Congenital Heart Disorder	☐ Frequent Headaches	☐ Hives or Rash	☐ Recent Weight Loss	☐ Tonsillitis
☐ Arthritis/Gout	☐ Convulsions	☐ Genital Herpes	☐ Hypoglycemia	☐ Renal Dialysis	☐ Tuberculosis
☐ Artificial Heart Valve	☐ Cortisone Medicine	☐ Glaucoma	☐ Irregular Heartbeat	☐ Rheumatic Fever	☐ Tumors or Growths
☐ Artificial Joint	☐ Diabetes	☐ Hay Fever	☐ Kidney Problems	☐ Rheumatism	☐ Ulcers
☐ Asthma	☐ Drug Addiction	☐ Heart Attack/Failure	☐ Leukemia	☐ Scarlet Fever	☐ Venereal Disease
☐ Blood Disease	☐ Easily Winded	☐ Heart Murmur	☐ Liver Disease	☐ Shingles	☐ Yellow Jaundice
☐ Blood Transfusion	☐ Emphysema	☐ Heart Pacemaker	☐ Low Blood Pressure	☐ Sickle Cell Disease	
☐ Breathing Problem	☐ Epilepsy or Seizures	☐ Heart Disease	☐ Lung Disease	☐ Sinus Trouble	
☐ Bruise Easily	☐ Excessive Bleeding	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Spina Bifida	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain _____

Do you take Bisphosphonate Drugs (ie: Actonel and Fosamax) ☐ Yes ☐ No

Preferred Pharmacy _____ Pharmacy Location & Phone _____

Current Medicines & Supplements _____

_____

_____

Date: _____ **Patient's Initials:** _____

Continued

Tarpon Shores
DENTAL

CHART # _____

MEDICAL HISTORY (Continued)

Please list name and phone numbers of all current Physicians.

1. _____ Phone _____

2. _____ Phone _____

3. _____ Phone _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes, please explain _____

_____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

If yes, please explain _____

_____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

If yes, which one? _____

Are you on a special diet? ☐ Yes ☐ No

If yes, please explain _____

Do you use tobacco? ☐ Yes ☐ No

Is there anything else we should know in order to help provide you with the best possible care?

_____

_____

_____

_____

_____

_____

_____

_____

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 _____ **DATE**_____

Notes_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Tarpon Shores
DENTAL

CHART # _____

DENTAL HISTORY

Patient First Name_____ Patient Last Name _____

Reason for this visit_____

Date of last dental visit? _____

Have you had any difficulty with dental treatment in the past? ☐ Yes ☐ No

If yes, please explain _____

_____

How often do you brush your teeth? _____

How often do you floss? _____

What other oral hygiene aids do you use? _____

Do your gums bleed while brushing or flossing? _____

Do you have tooth or gum pain with ☐ Hot ☐ Cold ☐ Sweet ☐ Biting

If yes, please explain _____

_____

Do you have a history of bite problems? ☐ Yes ☐ No

If yes, please explain _____

Do you have a history of headaches? ☐ Yes ☐ No

If yes, please explain _____

Do you clench or grind your teeth? ☐ Yes ☐ No

If yes, please explain _____

Do you have a history of broken teeth or fillings? ☐ Yes ☐ No

If yes, please explain _____

Do you have a history of periodontal disease? ☐ Yes ☐ No

If yes, please explain _____

On a scale of 1 to 10, with 10 being the highest, what priority do you give your teeth and oral health? _____

What goals do you have with your teeth and oral health?? _____

_____

What current dental concerns do you have? _____

_____

Are you happy with the appearance of your teeth and smile? _____

_____

If you could change anything about your mouth or smile, what would it be? _____

_____

What did you like most about your former dental office? _____

_____

What did you like least about your former dental office? _____

_____

Notes _____

_____

_____

_____

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Tarpon Shores
DENTAL

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment,
- A means of communication among health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.
- To disclose, as many be necessary, your health information (including HIV+/AIDS status, drug and alcohol treatment/abuse notes and qualified mental health notes to other healthcare providers and facilities (such as referrals to or consultations with, other healthcare pro fessionals, labs and hospitals) or any others as may be required by law or court order concerning your treatment payment and /or healthcare.
- To request from another healthcare entity and/or healthcare providers (ie doctors, dentists, hospitals, labs, imaging centers etc) specific healthcare information we may need for planning your care and treatment.

I have been provided the opportunity to review the *"Notice of Patient Privacy Information Practices"* that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the *"Notice"* prior to acknowledging this consent,
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment,

Restrictions

I request the following restrictions on the use or disclosure of my health information _____

May discuss treatment, payment, or healthcare operation with the following persons:

Please check all that apply ☐ Spouse ☐ Your Children ☐ Relatives ☐ Others ☐ Parents

Please list the names and relationship, if you checked "Relatives" or "Others" above_____

Messages or Appointment Reminders (Please check all that apply)

Messages will be of a non-sensitive nature, such as, appointment reminders.

May we leave a message on your answering machine ☐ At home ☐ At work ☐ **Do not leave a message**

May we leave a message with someone at your **home** using the doctor's name or the practice name ☐ Yes ☐ No

May we leave a message with someone at your **work** using the doctor's name or the practice name ☐ Yes ☐ No

Financial Agreement

I understand that the undersigned individual is obligated (him/her) and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. Payment of any unpaid balance is due within 90 days of the final billing. Finance charges may begin to accrue at the maximum rate by law. In addition, such balances may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and /or collection agency fees and expenses. The undersigned understands that Tarpon Shores Dental has the right to examine credit bureau files for financial information regardling the collection of unpaid debit.

I fully understand and accept the information provided by this consent. Signature _____

Print name of person signing_____ **Date** _____

*If other than patient is signing, are you the parent, legal guardian, custodian, or have Power of Attorney for this patient, for treatment, payment or healthcare operations? ☐ Yes ☐ No

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☐ Patient refused to sign the consent form.

☐ Restrictions were added by the patient (see restrictions listed above)

☐ "Consent form" received and reviewed by _____ Date _____

☐ "Consent form" placed in the patient's medical record on (date) _____