Patient Information

ONE PATIENT PHOTO IDENTIFICATION

Title:____First Name:_____________ Middle:____LastName: ______________________
Address: ____
City:_____________________State:________Zip Code: ___________________________
Home Phone:__________________________Business Phone: _______________________
SS#:_________________________________Cell Phone______________________
Gender:______Date of Birth:___________________
Employer:____
Name of Parent or Guardian: ____
E-mail: ____

Do you have Dental Insurance? Yes or No

Primary Subscriber Name:_______________Relationship to Patient:_________________
Date of Birth:__________________________Employer: ___________________________
I.D.#/ SS#:_____________________________Group or Plan #:_________________
Name of Insurance Carrier: ____
Address:____
City:_____________________State:________Zip Code: ____________________________
Phone Number:____

Secondary Insurance Information:

Secondary Subscriber Name:_____________Relationship to Patient:_________________
Date of Birth:__________________________Employer: ___________________________
I.D. #:________________________________Group or Plan #:_______________________
Name of Insurance Carrier:____
Address:____
City:_____________________State:________Zip Code:____________________________
Phone Number:____

Referral Source:____
General Dentist (if different):____
Emergency Contact: _____________________________________
Address: ____
City:_____________________State:________Zip Code: ____________________________
Phone Number: ______________________________________

I authorize Dontics Center to release any information including diagnosis and records of treatment or examination rendered to me or my child, to third party payors, and/or my health care providers. I authorize and request my insurance company to pay directly to Dontics Center any benefits payable to me. I understand that my insurance carrier may pay less than the actual bill of service. I agree to be responsible for all fees regardless of my insurance coverage. In the event that my payment is not received in 30 days of the due date, I agree to pay late fees, including but not limited to any reasonable legal fees necessary for collections.

____

Patient Signature Date

Medical History

Name: ________________________________ Date of Birth: _________________
Address: ______________________________ Telephone Number: _____________
Primary Physician's Name: ____
Primary Physician's Phone Number: ____
Date of Last Medical Examination: ____
Have you ever been hospitalized and/or had a serious illness? (If yes, please explain)
____
Are you using any recreational drugs? ____
Are you or might you be pregnant or nursing? Yes or No

Do you have or have you ever had any of the following: (If yes, please check box)

☐Heart problems/Heart murmur	☐Hepatitis/Liver disease
☐High blood pressure	☐Joint replacement
☐Rheumatic fever	☐Tumor/Cancer
☐Stroke/Circulatory problems	☐HIV/AIDS
☐Anemia/Bleeding	☐Herpes/STDs
☐Diabetes	☐Mental/Neural disorder
☐Kidney disease	☐Alcoholism/Addiction
☐Respiratory problems/Asthma	☐Infectious disease
☐Thyroid/Hormonal disorder	☐Blood disease
☐Ulcers/Digestive disorder	☐Arthritis
☐Epilepsy/Fainting spells	☐Radiation/Chemotherapy

Which medications are you currently taking? (Please include over the counter medications)____

Are you allergic to any of the following? **Reaction**: ____________________________

☐Penicillin	☐Narcotics
☐Other Antibiotics: _____________	☐Anesthesia
☐Aspirin	☐Latex
☐Codeine	☐Other: ________________

Do you have problems with any of the following?

☐Pain in teeth or gums	☐Pain in jaws
☐Sores on lips or mouth	☐Loose teeth

Does your jaw click, pop, or give you any discomfort? ___________________________
Have you ever had injury to the face, jaws, or neck? ____________________________
Do you have difficulty in opening your mouth wide? ____________________________
Have you ever had an unusual reaction to any dental treatment? ____________________
Do you smoke or chew tobacco? ____

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information may be dangerous to my health.

____
Patient Signature Date

5990 SW 40 St, Miami, Florida 33155

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Dontics Center this ___ day of ________, 20__. A copy of this signed, dated Acknowledgement shall be as effective as the original.

____
Please print your name

____
Please sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority ____.

Thank you, and if you have any questions about this form, please contact our Privacy Official.

Office Use Only

As Privacy Official, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign
because (please describe) __________________________

____
Signature of privacy official

APPOINTMENT POLICY

As a courtesy to our patients, we will attempt to confirm appointments 24 hours before their scheduled time. A nominal charge of **$ 50.00** will be made to your current balance for "failed" or "no-show" appointments without prior notification of cancellation by the patient (or guardian) **24 hours in advance**. This balance needs to be paid in full prior to or at the time of your next dental appointment. Please make sure that your personal information is always current to prevent this from happening.

Please remember, once an appointment is made, that time is **reserved for you**!

Thank you for your cooperation. Please let us know if you have any questions.

I, the undersigned, have read and understand the policy above and accept it.

Full Name:____

Signature:____

Date: ____