

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)

Email Address: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

\_\_\_\_\_ City State Zip Code

### Emergency Contact Information

Contact Person: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
 Contact Number: \_\_\_\_\_

### ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

NONE

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> ACID REFLUX            | <input type="checkbox"/> CANCER/MALIGNANCY   | <input type="checkbox"/> HEPATITIS             | <input type="checkbox"/> SINUS PROBLEMS             |
| <input type="checkbox"/> ADHD                   | <input type="checkbox"/> CEREBRAL PALSY      | <input type="checkbox"/> HIGH BLOOD PRESSURE   | <input type="checkbox"/> STROKE                     |
| <input type="checkbox"/> AIDS/HIV               | <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> KIDNEY DISEASE        | <input type="checkbox"/> TUBERCULOSIS               |
| <input type="checkbox"/> ANEMIA                 | <input type="checkbox"/> DEPRESSION          | <input type="checkbox"/> LIVER PROBLEMS        | <input type="checkbox"/> ULCERS                     |
| <input type="checkbox"/> ANOREXIA               | <input type="checkbox"/> EPILEPSY/SEIZURES   | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> OTHER – PLEASE LIST: _____ |
| <input type="checkbox"/> ANXIETY                | <input type="checkbox"/> DIABETES            | <input type="checkbox"/> MONONUCLEOSIS         | <input type="checkbox"/> Currently Pregnant         |
|   | CURRENT A1C _____                            |  | Due Date: _____                                     |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> HEARING PROBLEMS    | <input type="checkbox"/> PACEMAKER             |   |
| <input type="checkbox"/> ARTIFICIAL JOINTS      | <input type="checkbox"/> HEART ATTACK        | YEAR PLACED _____                              | <input type="checkbox"/> PSYCHIATRIC TREATMENT      |
| <input type="checkbox"/> ARTHRITIS              | YEAR _____                                   |  |   |
| <input type="checkbox"/> ASTHMA                 | <input type="checkbox"/> HEART DISEASE       | <input type="checkbox"/> RADIATION/CHEMO       |   |
| <input type="checkbox"/> BULIMIA                | <input type="checkbox"/> HEART MURMUR        | <input type="checkbox"/> RESPIRATORY DISEASE   |   |

### ALLERGIES/ALLERGIC REACTIONS

#### ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

- |  |                                  |   |   |                               |
|--|----------------------------------|---|---|-------------------------------|
| <input type="checkbox"/> ASPIRIN             | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE    | <input type="checkbox"/> SLEEPING PILLS               | <input type="checkbox"/> NONE |
| <input type="checkbox"/> ANESTHETIC – LOCAL  | <input type="checkbox"/> DAIRY   | <input type="checkbox"/> METAL SENSITIVITY      | <input type="checkbox"/> SULFA DRUGS                  |                               |
| <input type="checkbox"/> BARBITURATES        | <input type="checkbox"/> LATEX   | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS |                               |
| <input type="checkbox"/> OTHER – PLEASE LIST |                                  |   | (PLEASE LIST BELOW)                                   |                               |

### MEDICATION INFORMATION

#### ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

NONE

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY    | <input type="checkbox"/> DAILY ASPIRIN               | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS |
| <input type="checkbox"/> BLOOD THINNERS          | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS  | <input type="checkbox"/> CORTISONE/STEROIDS          | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN                 | <input type="checkbox"/> NITROGLYCERIN             | <input type="checkbox"/> ORAL CONTRACEPTIVES         | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS   |
| <input type="checkbox"/> RECREATIONAL DRUGS      | <input type="checkbox"/> THYROID MEDICATIONS       | <input type="checkbox"/> TRANQUILIZERS               | <input type="checkbox"/> OTHER DIABETIC MEDICATIONS |
| <input type="checkbox"/> OTC DRUGS/ MEDICATIONS  | <input type="checkbox"/> OTHER (PLEASE LIST BELOW) | <input type="checkbox"/> FOSAMAX /<br>BISPHOSPHONATE |   |
- (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

**\*PHARMACY NAME/LOCATION & PHONE:** \_\_\_\_\_

## Responsible Party Information or Insurance Policy Holder

person responsible for payment  Insurance Policy Holder

Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_

Address: \_\_\_\_\_

Street

Apartment #

City

State

Zip Code

## Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative

Yellow Pages  Ocala Star Banner  Google  OTOW  Radio  Good Life Magazine

Billboard HWY 40/ HWY 200

Name of person or office referring you to our practice: \_\_\_\_\_

## Employment Information

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand if my insurance company pays less than the estimate shown on the treatment plan, regardless of any pay today courtesy offered, the unpaid insurance balance is due by the patient.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Any request for records may incur fees of up to \$25.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I understand that in order for our doctors to see all our patients in a timely manner, cancellations or changes to any appointments must be made prior to 24 business hours or 48 business hours for any surgical appointments that may include implant, sinus lift or oral surgery procedures of your scheduled appointment to avoid a fee. Fee is determined based on length of appointment time and procedure scheduled.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

To the best of my knowledge, all of the preceding answers regarding my medical history are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

\_\_\_\_\_  
Signature of patient, parent or guardian

Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party

Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_