Chart #: ___________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)

Gender: Male Female Family Status: Single Married Child Widowed Other

Social Security #: _______________ Birth Date: _____________ Email: ______________________________

Phone (Home): ______________ (Cell): _________________ (Work): __________________ Ext: ________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ____
Street Apartment #

____
City State Zip Code

Medical History

Do you have or had any of the following? Please check those that apply:

☐ AIDS/HIV	☐ Headaches	☐ Pacemaker	Drug Allergies :
☐ Arthritis	☐ Head Injuries	☐ Psychiatric Care	☐ ________________
☐ Artificial Heart Valve/Stent	☐ Heart Attack Yr.?__________	☐ Radiation Treatment	
☐ Asthma	☐ Heart Infection	☐ Respiratory Disease	☐ ________________
☐ Back Problems	☐ Heart Murmur	☐ Rheumatic Fever	
☐ Blood Disease/Hemophilia	☐ Hepatitis Type:______	☐ Sinus Problems	Medications currently
☐ Cancer _______________	☐ Blood Pressure High Low	☐ Stroke Yr.?________	taking:
☐ Chemical Dependency	☐ Jaundice or Liver Disease	☐ Swollen Neck Glandes	☐ ________________
☐ Cholesterol	☐ Kidney problems	☐ Tumor or growth head/neck	
☐ Circulatory Problems	☐ Mental Disorders	☐ Thyroid Disease	☐ ________________
☐ Diabetes Type:________	☐ Mitral Valve Prolapse	☐ Ulcer	
☐ Epilepsy	☐ Nervous Disorders	☐ Venereal Disease	Birth control? Yes No

- ***Artificial Joint replacement*** Have you had an orthopedic total or partial joint? ☐ Yes ☐ No Hip Knee Other?
  If yes, Date: ______________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ____ Phone: _________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- ***Women ONLY***: Are you pregnant at this time? ☐ Yes ☐No Due Date: _____/______/_____ Nursing? Yes

Name of OB/GYN: ____ Phone: __________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ___________________
Signature of patient, parent or guardian

Referral Information

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

☐ Dental Office ☐ Insurance ☐ Newspaper ☐ School ☐ Work ☐ Other ______________________

Name of person or office referring you to our practice: ____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________________

Social Security #: ________________________ Birth Date: ________________________

Phone (Home): ________________ (Work): ________________ Ext: ______ Best time to call: ______________

Address: ____

Street Apartment #

____

City State Zip Code

Minor/Child Consent

I, being the parent or guardian of ______________________________do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: _______________ Signature of Insured Guardian____

Insurance Information

Primary

Name of Insured: ____ is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #: ______________________

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________________________

Secondary

Name of Insured: ____ is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #: ______________________

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________________________

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. Anna Maria Island Dental 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.

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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Anna Maria Island Dental, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. 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 grant my permission to Anna Maria Island Dental or 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.

______________________________________ Date: ____________ Relationship to Patient: ______________________

Signature of patient, parent or guardian

______________________________________ Date: ____________ Relationship to Patient: ______________________

Signature of guarantor of payment/responsible party

ANNA MARIA ISLAND DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, patients **with** Insurance in refusing we ***will not be allowed*** to process your Insurance Claims.

Date: __________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Anna Maria Island Dental. A copy of this signed, dated, and acknowledgement shall be as effective as the original.

Print your name: ________________________________Sign your name: ______________________________________

Legal Representative: ____________________________Description of Authority: ________________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name: ____Relationship:____

Name: ____Relationship:____

I authorize contact from this office to ***confirm my dental appointments*** VIA:

- ☐ Cell phone
- ☐ Home phone
- ☐ Work phone
- ☐ Text message
- ☐ Email

I authorize ***information about my dental health be conveyed*** VIA:

- ☐ Cell phone
- ☐ Home phone
- ☐ Work phone
- ☐ Text message
- ☐ Email
- ☐ in person
- ☐ any of above

I approve being contacted about ***special services, events, or new dental info*** VIA:

- ☐ Phone message
- ☐ Text message
- ☐ Email
- ☐ Any of above

For office use only

As Privacy Officer, I attempted to obtain the patients (or representatives) signature on this acknowledgement but did not because:

_____Individual refused to sign

_____Communication barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (Please Specify) Signature of Privacy Officer______________________________________

Dental History

Patient Name: _______________________________ Reason for today's visit: Cleaning Emergency

Date of Last Dental Visit: ______________________ Reason for this visit: __________________________

How often do you brush daily? 1 2 3 Do you floss Daily? Yes No

What kind of toothbrush do you use? Electronic Manual

Please check if you have or had:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette/pipe/cigar smoking
- ☐ Smokeless tobacco
- ☐ Gums swollen, tender, bleeding
- ☐ Lip or cheek biting
- ☐ Loose teeth/broken fillings
- ☐ Mouth breathing
- ☐ Orthodontic treatment
- ☐ Periodontal(gum) treatment
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Clench or grinding teeth
- ☐ Head, neck, or Jaw pain
- ☐ Growths/sore spots in mouth
- ☐ Sensitivity when biting
- ☐ Sensitivity to pressure or irritants
  - Cold
  - Hot
  - Sweets

Have you ever had an allergic reaction to novocaine, local or general anesthetics? ☐ Yes ☐ No

If Yes, Please explain: ____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: ____