Pensacola Family Dentistry

911 Garden Gate Circle • Pensacola, FL 32504-8629 (850)477-7574

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

SS#: ___-__-____

Prev. Visit: _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) ____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Employment

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

I prefer to be contacted by

☐ Cell phone/Text ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

_____

In an emergency, who should be notified? Please enter name, phone number and relationship below

_____

_____

Responsible Party

This page ONLY needs to be completed if the insurance subscriber is OTHER than the patient AND/OR you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

SS#: ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Insurance Authorization

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Do you have secondary dental insurance? ◯ Yes ◯ No

Dental Information and Medical History

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist Name and Phone Number

Approximate date of most recent dental exam and/or dental x-rays

I routinely see a dentist every

◯ 3 mos ◯ 4 mos ◯ 6 mos ◯ 12 mos ◯ Not routinely

What is your immediate concern about your dental health?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply

- ☐ Complications from past dental treatment
- ☐ Reactions to local anesthetic
- ☐ Experiences dry mouth
- ☐ Food gets trapped between teeth
- ☐ Popping and/or clicking of your jaw joint
- ☐ Clenching or grinding of teeth
- ☐ Wears removable partial/denture
- ☐ Diagnosed and/or treated for gum disease
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Teeth become loose on their own (without injury)
- ☐ Trouble getting numb
- ☐ Past/Present braces or orthodontic treatment
- ☐ Sensitive to hot, cold, biting, sweets
- ☐ Whitened or bleached your teeth
- ☐ Difficulty chewing
- ☐ Currently or previously wore a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Bone loss around your teeth
- ☐ Experienced gum recession
- ☐ Snores or wakes up frequently during the night

If any of the checked boxes need further explanation, please describe:

- [ ] ADD/ADHD
- [ ] Allergy Anesthetic
- [ ] Allergy Bactrim
- [ ] Allergy Dairy
- [ ] Allergy Keflex
- [ ] Allergy Nitrous
- [ ] Allergy Sulfa
- [ ] Anemia
- [ ] Artificial Joints
- [ ] Autism
- [ ] Cancer
- [ ] Dementia
- [ ] Down Syndrome
- [ ] Fibromyalgia
- [ ] Hearing Impairment
- [ ] Heart Problems
- [ ] High Cholesterol
- [ ] Lupus
- [ ] Osteoporosis
- [ ] Respiratory Problems
- [ ] Sinus Problems
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [ ] Valve Replacement
- [ ] AIDS / HIV infection
- [ ] Allergy Aspirin
- [ ] Allergy Benadryl
- [ ] Allergy Epinephrine
- [ ] Allergy Latex
- [ ] Allergy NSAIDs
- [ ] Allergy Tetracycline
- [ ] Angina
- [ ] Asperger's Syndrome
- [ ] Blood Disease
- [ ] Celiac Disease
- [ ] Depression
- [ ] Emphysema/COPD
- [ ] GERD
- [ ] Heart Attack
- [ ] Hemophilia
- [ ] Kidney Disease
- [ ] Mental Illness
- [ ] Pacemaker
- [ ] Rheumatic Fever
- [ ] STD
- [ ] TMD
- [ ] Tumors
- [ ] Allergies
- [ ] Allergy Augmentin
- [ ] Allergy Cleocin
- [ ] Allergy Erythromycin
- [ ] Allergy Lortab
- [ ] Allergy Penicillin
- [ ] Allergy Tylenol
- [ ] Anxiety
- [ ] Asthma
- [ ] Blood Thinner-Takes
- [ ] Circulatory Problems
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] Liver Disease
- [ ] MVP
- [ ] Radiation Treatment
- [ ] Rheumatism
- [ ] Stomach Problems
- [ ] Tourette Syndrome
- [ ] Ulcerative Colitis
- [ ] Allergy Amoxicillin
- [ ] Allergy Azithromycin
- [ ] Allergy Codeine
- [ ] Allergy Ibuprofen
- [ ] Allergy Metals
- [ ] Allergy Steriods
- [ ] Alzheimer's
- [ ] Arthritis
- [ ] Atrial Fibrillation
- [ ] C. Diff
- [ ] Crohns
- [ ] Dizziness
- [ ] Fainting
- [ ] Head Injuries
- [ ] Heart Murmur
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Nervous Disorders
- [ ] Recent Surgery
- [ ] Seizures
- [ ] Stroke
- [ ] Tremors/Parkinsons
- [ ] Ulcers

- [ ] Pregnant/Planning Pregnancy/Nursing
- [ ] No Medical Conditions
- [ ] No Health Changes

Please clarify the conditions or alerts selected including due date if pregnant:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

Name of physician and date of last physical exam

Name and phone number of preferred pharmacy

Are you taking any medications (prescription and Non-prescription) if yes please explain below *

Do you have any allergies and/or allergies to medications. If yes, please explain below * *

Do you have any allergies and/or allergies to medications. If yes, please explain below * *

_____

_____

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. I further consent to the performing of xrays and oral examinations. This will serve as my electronic signature.**

Name of Patient/Parent or Guardian completing this form *

_____

_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As a curtesy, we will file your insurance claims and the insurance company will pay us directly. This is not a guarantee of payment from the insurance company and any amount not paid by patient insurance is the responsibility of the patient.

I understand that any fee estimate for this dental care can only be extended for a period of 30 days from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (7) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 you or your assignee, to telephone me to discuss this statement or my treatment.

When you schedule an appointment, we reserve that time specifically for you. We require at least a 48 hour notice of cancellation or a minimum of at least $40 no show charge may be incurred.

◯ Yes ◯ No

☐ ***By checking this box, I understand the above information and agree with its contents and this will serve as my electronic signature for the AdministrationForm.**

HIPAA Acknowledgment/Consent for Internet Communications

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

_____

_____

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Response Date: _____