

Thank you for choosing Family Dentist of Palm Beach, Inc. for your dental care needs! We promise to do our very best to provide you with the finest care available. To help us meet your entire dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help you.

1. Personal Information

Patient Name: Last _____, First _____ Middle Initial _____

Gender: Male Female Preferred Name: _____

Family Status: Single Married Child Other _____

Birth Date _____ Soc. Sec.# _____ Drivers Lic _____

Address _____

City, State, Zip _____

Email _____

Home # _____ Work # _____ Mobile # _____

Whom may we thank for referring you to our practice?

Website: _____ Coupon Yellow Pages

Name of friend, family or other source referring you to our practice:

Other: _____

2. Responsible Party (If someone other than the patient)

Name: Last _____, First _____ Middle Initial _____

Relationship to patient: Self Spouse Parent Other _____

Birth Date _____ Soc. Sec.# _____ Drivers Lic _____

Address _____

City, State, Zip _____

Email _____

Home # _____ Work # _____ Mobile # _____

Policy Holder for Patient Primary Insurance Policy Holder

3. Contact Information

Where do you prefer to receive calls, in the order of preference? ___Home ___Work ___Mobile

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, whom should we contact?

Name _____ Relationship _____

Email _____

Home # _____ Work # _____ Mobile # _____

4. Dental Insurance Information

Name of Insured: _____
Relationship to Patient: Self Spouse Parent Other _____
Insured Birth Date: _____ Insured Soc. Sec. # _____
Insurance Company: _____ Insurance Co Phone # _____
Group #: _____ ID #: _____
Remaining Benefits: _____ Remaining Deductible: _____

5. Employment Information

Employer Name: _____ Phone: _____
Address _____
City, State, Zip _____

6. Financial Arrangements

For your convenience, we offer the following methods of payment.

Please check the option, which you prefer.

_____ Cash
_____ Personal Check
_____ Debit Card _____ Visa _____ MC Credit Card # _____
_____ Exp Date _____
_____ Third party financing
_____ I wish to discuss the dental office's policy.

**** Payment is required in full before any service is rendered, please have payments in full at each appointment. ****

7. Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Please check the following for authorization:

- I authorize the release of information to my spouse/relative: _____
- I authorize the office to contact me regarding any treatment recommended/diagnosed by the doctor.

Signature of patient or parent if minor

Date

Health History

Patient Name _____ Birth Date _____

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 that you will be receiving. Thank you for answering the following questions.

A. Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? Soft Medium Hard

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
5. Do your gums bleed while brushing?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you bite your lips or cheeks often?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you feel pain to any of your teeth when brushing or flossing them?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever had:		
7. Are your teeth sensitive to hot, cold, sweet, or sour foods/liquids?	<input type="checkbox"/>	<input type="checkbox"/>	a. Orthodontic treatment (braces)	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you noticed any loosening of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	b. Gum treatment	<input type="checkbox"/>	<input type="checkbox"/>
9. Does food tend to become caught between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	c. Your teeth ground or the bite adjusted	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	16. Are you satisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever experienced any of the following problems in your jaw?			* Rate your smile on a scale of 1-10, with 10 being perfect: _____		
a. Clicking	<input type="checkbox"/>	<input type="checkbox"/>	17. Have you ever had an upsetting experience in the dental office?	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	* If yes, please explain: _____		
c. Difficulty in opening/closing jaw	<input type="checkbox"/>	<input type="checkbox"/>	_____		
d. Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>	_____		
12. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	18. Is there anything about dental treatment that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you clench/grind your teeth while awake/asleep?	<input type="checkbox"/>	<input type="checkbox"/>	* If yes, please explain: _____		

B. Medical History

Yes No

- Are you under a physician's care now? If yes, Physician's name: _____
Office/Phone # _____
- Have you ever been hospitalized/had a major operation?

- Have you ever had a serious head/neck injury?

- Do you take, or have you taken, Phen-Fen or Redux? _____
- Are you on a special diet? _____
- Do you use tobacco?
- Do you use controlled substances?
- Are you taking any medications, pills, or drugs? If yes, please list all your medications: _____

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No

Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal
 Latex Local Anesthetics Other, please explain: _____

Do you have, or have you had, any of the following?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Troubles	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had any serious illness not listed above? Yes No

If yes, please explain: _____

Comments: _____

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 or parent if minor

Date