Dental Registration & Health History

Independent Dental Care (239) 437-8900
9131 College Pkwy Unit 150 Ft Myers, FL 33919

Patient Information Date _____

First Name _____ Last Name _____ MI _____

Date of Birth _____ Preferred Name _____ ⬜Female ⬜Male

Home Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email Address _____

Employer _____ Occupation _____

Name(s) of Spouse and/or Children _____

Referred By _____ Full time resident? ⬜Yes ⬜No

Do you have dental insurance? ⬜Yes ⬜No Provider _____

Emergency Contact

Name _____Relation _____ Phone _____

Parent/Guardian Information (if patient is a minor)

First Name _____ Last Name _____ MI _____

Date of Birth _____Relation _____ ⬜Female ⬜Male

Address (if different than above)_____

Phone _____ Email Address _____

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, consent to the dental and oral surgical procedures agreed to by myself (or guardian) and the dentist to be necessary or advisable, including the use of local anesthetic and radiographs as indicated. I understand that I am responsible for payment for all treatment rendered. I grant the dentist the right to release health information obtained from me and information about my dental treatment to health practitioners in emergency situations.

_____ _____ _____

Please **PRINT** your name | Please **SIGN** your name | Date

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

The undersigned acknowledges a copy of the currently effective Notice of Privacy Practices has been made available to me for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____ _____
Please **PRINT** your name Please **SIGN** your name Date

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

Name: _____ Phone:_____Relationship: _____

Name: _____ Phone:_____Relationship: _____

RELATED INFORMATION

1. Payment is due at the time of service. Acceptable forms of payments include cash, check or credit card (Visa, Mastercard, Discover and American Express). Third party financing is accepted in the form of Care Credit.
2. Balances older than 30 days may be subject to additional collection fees and interest charges of 2% per month or 18% annually. Returned checks will be assessed additional fees and will be turned over to the county attorney's office for collection if not paid timely.
3. In the event the account is not paid, and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs, and collection agency fees).
4. Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. 24-hour notice is needed to avoid a charge.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

_____ _____ _____
Please **PRINT** your name Please **SIGN** your name Date

DENTAL HEALTH HISTORY

Last dental visit _____ Last dental cleaning _____ Last dental x-rays _____

Previous Dentist _____ Location _____

Reason for your visit _____

How often do you brush your teeth? _____ Floss? _____

Do you have missing teeth? ⬜Yes ⬜No Are you interested in replacing them? ⬜Yes ⬜No

Have you ever been treated for periodontal disease? ⬜Yes ⬜No Date _____

Have you ever had orthodontic braces? ⬜Yes ⬜No Date _____

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Name_____ Birth Date _____ Date _____

Are you under a physician's care? ⬜Yes ⬜No

Are you currently being treated for anything?_____

Physicians Name _____ Phone Number _____

Have you ever been hospitalized or had a major operation? ⬜Yes ⬜No

If yes _____

Have you ever had a serious head or neck injury? ⬜Yes ⬜No

If yes _____

Are you taking any medication, pills, or drugs? ⬜Yes ⬜No

List all current medications (please let us know if you need more space)

Medication Name	Dosage	Purpose

Do you take, or have you taken, Phen-fen or Redux? ⬜Yes ⬜No

If yes _____

Have you ever taken Fosamax, Boniva, Acetonel or any other bisphosphonates? ⬜Yes ⬜No

If yes _____

Are you on a special diet? ⬜Yes ⬜No Do you use tobacco? ⬜Yes ⬜No

Do you use controlled substances? ⬜Yes ⬜No

If yes _____

Female: Are you ⬜Pregnant/Trying to get pregnant ⬜Nursing ⬜ Taking oral contraceptives

Are you allergic to any of the following?
⬜Aspirin ⬜Penicillin ⬜Codeine ⬜Acrylic ⬜Meta ⬜Latex
⬜Sulfa Drugs ⬜Epinephrine ⬜Other _____

If yes _____

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

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

Have you ever had any serious illness not listed above? ⬜Yes ⬜No If yes, _____

_____

Do you need to premedicate before dental appointments? ⬜Yes ⬜No If yes, _____

_____

Additional 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 health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent or Guardian Date