MEDICAL HISTORY

Physician's Name and Phone: _____ **Date of Last Physical:** _____

Have you ever had any of the following? ***(check boxes that apply)*:**

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	1. Heart Problems	☐	☐	11. Respiratory Problems	☐	☐	20. General Allergies	☐	☐	29. Ulcer
☐	☐	2. High Blood Pressure	☐	☐	12. Epilepsy	☐	☐	21. Blood Disease	☐	☐	30. Venereal Disease
☐	☐	3. Low Blood Pressure	☐	☐	13. Headaches	☐	☐	22. Arthritis	☐	☐	31. Hemophilia
☐	☐	4. Circulatory Problems	☐	☐	14. Hepatitis, Jaundice or Liver Disease	☐	☐	23. Special Diet	☐	☐	32. Nervous Problems
☐	☐	5. Heart Murmur	☐	☐	15. Cancer	☐	☐	24. Swollen Neck Glands	☐	☐	33. Excessive Bleeding
☐	☐	6. Radiation Treatment	☐	☐	16. Psychiatric Care	☐	☐	25. Rheumatic Fever	☐	☐	34. Tuberculosis
☐	☐	7. Artificial Heart Valves	☐	☐	17. Allergies to Latex	☐	☐	26. Sinus Problems	☐	☐	35. Alcohol Addiction
☐	☐	8. Artificial Joints	☐	☐	18. Allergies to Anesthetics	☐	☐	27. A.I.D.S.	☐	☐	36. Drug Addiction
☐	☐	9. Back Problems	☐	☐	19. Allergies to Medicines or Drugs	☐	☐	28. Stroke	☐	☐	37. HIV Positive
☐	☐	10. Diabetes							☐	☐	38. Have you taken Fen phen or Redux

_____

_____

_____

_____

_____ Dr. Signature: _____ Date: _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

List all medication being taken: 1. _____ For what condition? _____

2. _____ For what condition? _____

3. _____ For what condition? _____

4. _____ For what condition? _____

If the patient is a child: weight: _____ lbs.

Are you under the care of a physician? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Due Date: _____ Are you nursing? ☐ Yes ☐ No

MEDICAL HISTORY UPDATE: _____ **Date:** _____

Reason for requesting dental care: _____

Informed consent: This is to certify that I, undersigned, authorize Doctor to take radiographs, study models, photographs, or any other diagnostics aids deemed appropriate by Doctor to make a thorough diagnosis of patient's needs. I also authorize Doctor to perform any and all forms of treatment agreed to be necessary or advisable, including use of local anesthetics and medication as indicated, and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I understand that as a service to me this dental office will assist me in processing my insurance claims. However, I am completely responsible for all fees in their entirety.

Payment is due at the time services are rendered.

X _____ Date: _____

Signed (patient or parent if minor)

ONLY if you have insurance SIGNATURE ON FILE!

So that you do not have to sign an insurance form at each dental visit, this dental office will maintain this *"signature on file"* for you.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize ant Provider, Insurer or other Organization to release any information reguarding the dental history, treatment or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

X _____ Date: _____

Signed (patient or parent if minor)

AUTHORIZATION TO PAY BENEFITS TO BELOW NAMED DENTIST: I hereby authorize payment directly to this dental office for services rendered.

X _____ Date: _____

Signed (patient or parent if minor)

The highest compliment our patients can give us is the referral of their friends and family. Thank you for your trust.

DENTAL ARTS OF PALM AVENUE
REGISTRATION FORM

Name: (Last) _____ (Middle Initial) _____ (First) _____ **Age:** _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Social Security Number: _____

Telephone: (Home) _____ (Cell/Work) _____ Birthdate: _____ Sex: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employed By: _____

Employer's Address: _____ Phone: _____

If self-employed, name of business/address: _____ Phone: _____

☐ YES ☐ NO Are you a full time student? If so, which school? _____

Referred By: ☐ Friend/Patient: _____ ☐ Insurance Plan: _____ ☐ Yellow Pages ☐ Sign ☐ Ad/Flyer

Spouse's Name: _____ Social Security Number: _____

Occupation: _____ Work Phone: _____

Birthdate: _____ Employer: _____

Employer's Address: _____

Person to notify in an emergency (not living with you): _____ Phone: _____

Method of Payment: ☐ Cash ☐ Check ☐ Credit/Debit Card

Dental Insurance Information

Subscriber is: ☐ Self ☐ Husband ☐ Wife ☐ Mother ☐ Father Insurance Plan Number: _____

Name of Employer: _____

Employee's Name: _____ Social Security Number: _____

Insurance Co. _____ Group Number: _____ Date of Birth: _____

Insurance Co. Address: _____ Insurance Co. Phone: _____

☐ YES ☐ NO Are you covered by a second insurance company?

If yes, name of 2nd insurance company: _____ Group Number: _____

Employee Name: _____ Social Security Number: _____

Date of Birth: _____

Must complete if under 18 or full time student/Responsibility Party Information Required

Mother's Name: _____ Mother's Social Security No: _____

Mother's Address: _____

Mother's Home Phone Number: _____ Date of Birth: _____

Employer: _____ Occupation: _____ Work Phone: _____

Father's Name: _____ Father's Social Security No: _____

Father's Address: _____

Father's Home Phone Number: _____ Date of Birth: _____

Employer: _____ Occupation: _____ Work Phone: _____

Please Turn The Page!

DENTAL ARTS
of Palm Avenue

APPOINTMENT POLICY:

At Dental Arts of Palm Ave we believe completing your diagnosed treatment plan is essential to achieving optimum oral health.

In order to provide ease and convenience in keeping your appointments at Dental Arts of Palm Ave - please answer the following:

1. Preferred day for appointments? _____
2. Preferred time for appointments? _____

Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try to do our best. We work very hard to stay on schedule so that our valuable patients will not spend time in our reception area. A scheduled appointment is a commitment of time between you and our practice. We have reserved that time *just for you.* When appointments are missed or cancelled, that time is permanently lost.

We ask when you schedule an appointment that you make every effort to keep that commitment. Personal emergencies sometimes occur, and we always take that into consideration when receiving a last minute cancellation. If you find you cannot keep your reserved time, we ask you to provide a minimum of 48- hours notice to us so we may schedule another patient in need of treatment. Otherwise, a fee of $40 per appointment hour will be charge to the patient . For your convenience, our office administrative staff is available to serve you Monday through Thursday 9 a.m. to 6p.m. and Friday 8 a.m. to 5 p.m.

If you have any questions regarding this policy please do not hesitate to contact us. We sincerely appreciate your cooperation with this matter.

Signature: _____ Date: _____

FINANCIAL POLICY:

In order to provide ease and convenience with the financial plan for your treatment at Dental Arts of Palm Ave - please answer the following:

1. Preferred payment plan for treatment: Pay as you go ____ Payment in full _____ Monthly payments____
2. Preferred payment method for treatment: Cash Check MasterCard/Visa Discover American Express Citi Healthcard (oac) or Dental Fee Plan (oac)

At Dental Arts of Palm Ave we are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are committed to providing you with up-to-date information and educational tools so that you may fully appreciate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and the insurance company. Our office is not a party to that contract.

As a courtesy to you we will help in the processing of your insurance claims. You may direct your benefit payments to be made directly to our office. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance coverage to your initial appointment. Payment is due at the time service is provided. Small, monthly payments and interest-free payment options can be obtained through outside financing (on approved credit).

Balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Returned checks will be subject to a $25.00 fee. If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

Signature: _____ Date: _____

GENERAL DENTISTRY INFORMED CONSENT

NAME_____ **CHART** _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings_____, Bridges_____, Crowns_____, Extractions_____, Impacted teeth removed_____, Root Canals_____, Dentures_____, Exam & Xrays___X_____. (Initals _____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching
vomiting, and/or anaphalactic shock. (Initials_____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____)

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____ and any others necessary for reasons in paragraph # 3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility. (Initials_____)

5. CROWNS, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the definitive crowns are delivered. I realize the final opportunity to make changes in ny new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for final cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying final cementation. (Initials_____)

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the root which does not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost despite all effort to save it. (Initials_____)

7. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.
(Initials_____)

8. FILLINGS

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after
effect of a newly placed filling.
(Initials_____)

9. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that is my responsibility to retum for delivery of the dentures. I understand that failures to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my
delays of more than 30 days, there will be additional charges.
(Initials_____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledged that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist nor Dental Arts of Palm Ave is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries of Dental Arts of Palm Ave to proceed with and perform the dental restorations and treatments as explained to me. I understand that this cost is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collecting fees, or court costs that may be incurred to satisfy this obligation.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature_____
Date:_____
(Patient **or** Gttardlan)

Doctor_____
Witness:_____