



386.426.2191
www.atlanticdental.net

611 South Dixie Freeway
New Smyrna Beach, FL 32168

Today's Date: _____

Patient's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	Social Security Number:
Address (Street & Apartment #)	Patient Is: <input type="checkbox"/> Minor <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Student <input type="checkbox"/> Widowed	Home Phone ()	Cell Phone ()
Address (City, State & Zip)		Employed <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Other	Employer:
Email:		Emergency Contact:	Employer Phone: ()
Spouse's or Parent's Name (if patient is a minor)		Emergency Contact Phone: ()	How Did You Hear About Our Office?

MEDICAL HISTORY

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes _____

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 medications, pills, or drugs? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? Yes No If yes _____

Do you take any arthritis medications? Yes No If yes _____

Do you currently take blood thinners? Yes No If yes _____

Do you require a pre-medication? Yes No If yes _____

Are you on a special diet? Yes No If yes _____

Do you use any form of tobacco? Yes No If yes _____

Do you use controlled substances? Yes No If yes _____

Woman: Are you

Pregnant? If yes, due date? _____ Trying to get pregnant? Nursing?

Are you using contraceptives?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Other allergies? Yes No If yes _____

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

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

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

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 an any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

Responsible Party:

Name: _____ Relationship to Patient: _____

Address: _____ City, State Zip _____

DOB: _____ Phone: _____

Employer: _____ Employer Phone: _____

The following protected health information may be released to the above individual

_____ Billing & Account Information

_____ Treatment Information

Dental Insurance Information

Name of Policy Holder: _____ Relationship to Patient: _____

Address: _____ City: _____ St: _____ Zip: _____

Home #: _____ Cell #: _____ Office #: _____

Policy Holder's Birth Date: ____/____/____ Policy Holder's SS #: _____

Insurance Company: _____ Phone #: _____

Policy Holder's Employer: _____

Secondary Dental Insurance Information

Name of Policy Holder: _____ Relationship to Patient: _____

Address: _____ City: _____ St: _____ Zip: _____

Home #: _____ Cell #: _____ Office #: _____

Policy Holder's Birth Date: ____/____/____ Policy Holder's SS #: _____

Insurance Company: _____ Phone #: _____

Policy Holder's Employer: _____

Financial Agreement

_____ I understand payment is due at the time of service. If I have dental insurance I agree to pay my estimated out of pocket at the time of treatment.

_____ I understand insurance is just an estimate and benefits are determined by the employer not Atlantic Family Dentistry. It is my responsibility to understand my insurance plan.

_____ I understand that some insurance companies require a co-pay and I am personally responsible for all co-pays and late payment penalties.

_____ I agree I am responsible for notifying Atlantic Family Dentistry of any insurance change I may encounter.

I hereby authorize and direct Atlantic Family Dentistry as assisted by other dentists and auxiliaries, to perform any necessary dental treatment.

All patients under the age of 18 must have a parent or legal guardian present for all scheduled appointments.

Patient / Parent / *Legal Guardian Signature: _____

Printed Patient / Parent / *Legal Guardian Signature: _____

Relationship to Patient: _____ **Date:** _____

**If signed by a patient's authorized representative, or legal guardian, supporting legal documentation must accompany this authorization form.*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

Employee signature

Date