Palm Harbor
Dental Care,
PLLC

NAME: _____
FIRST MI LAST PREFERRED

ADDRESS: _____ **CITY** _____ **ST** _____ **ZIP:** _____

SSN: _____ **DOB:** _____ **CELL PHONE:** _____

M/F: (Circle One) SINGLE/MARRIED/MINOR (Circle One) EMPLOYER: _____

WORK# _____ **EMAIL:** _____

EMERGENCY CONTACT: _____ **PHONE #** _____

RELATIONSHIP TO PATIENT: _____

REFERRED BY : _____

(Please fill out the information below if you are NOT the primary insured)

NAME OF INSURED: _____ **RELATIONSHIP TO INSURED:** _____

DATE OF BIRTH: _____ **SSN:** _____ **EMPLOYER:** _____

TEL: # _____ **ADDRESS: (Include City & State)** _____
**

HIPAA PRIVACY AUTHORIZATION

Authorization for Use or Disclosure of Protected health (Required by the Health Insurance Portability and Accountability Act. 45 C.F.R. Parts 160 and 164) **

I authorize Palm Harbor Dental to use and disclose the protected dental information including treatment plans, payments and appointment dates to _____(family member. trusted individual).
This authorization for release of information covers the period from:

a. _____ **to** _____
OR

b. **all past, present and future periods (Circle)**

Financial Policy:

I understand that I am responsible for any and all fees related to my dental care needs.
I understand that a deposit will be required to schedule an appointment. Reminder of all fees must be paid at the time services are rendered.
I understand interest charges will be added to the account after 30 days of any charges not paid and may be turned over to a collection agency.
I understand that I will be responsible for any balances if insurance does not pay for or denies any portion of the claim.
I understand I am only paying the estimated portion (the portion not covered by insurance) at the time of services.
I understand I will be charged a cancellation fee ($25.00) for any appointment cancelled within 24 hrs. of my appointment time.
I authorize and request my insurance be submitted to my carrier on my behalf.
I have read, understood and agree to the HIPAA and Financial Policies. _____ **Initial**

Thank you for filling out this form completely. This will help us provide you with the best dental care possible.

X_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

Medical History

Patient Name: _____ Date: _____

Physicians Name: _____ Office Phone: _____

Date of Last Exam: _____ (Please circle either Y for yes or N for NO)

Are you under medical treatment now? Y or N
Have you ever been hospitalized for any surgical operations or serious illness within the past 5yrs? Y or N
If yes, please explain_____

Are you taking any medications including non-prescribed? Y or N
Please List_____

Have you ever taken bisphosphonates or bone loss medications? Y or N
Do you use tobacco? Y or N
Do you use controlled substances? Y or N
Are you wearing contact lenses? Y or N

Are you allergic to or have you had any reactions to the following?

Local Anesthetics	Y or N
Penicillin or other antibiotics	Y or N
Sulfa Drugs	Y or N
Barbiturates	Y or N
Sedatives	Y or N
Iodine	Y or N
Aspirin	Y or N
Any Metals	Y or N
Latex Gloves	Y or N

Other_____

Do you have a persistent cough or throat clearing not associated with any known illness? Y or N
Women Only: Are you nursing? Y or N
Are you pregnant or think you may be? Y or N
Are you taking Oral Contraceptives? Y or N

Do you have any of the following:

High Blood Pressure	Y or N	Heart Disease	Y or N	Chest Pains	Y or N
Heart Attack	Y or N	Cardiac Pacemaker	Y or N	Easily Winded	Y or N
Rheumatic Fever	Y or N	Heart Murmur	Y or N	Stroke	Y or N
Swollen Ankles	Y or N	Angina	Y or N	Hay Fever/Allergies	Y or N
Fainting/Seizures	Y or N	Frequently Tired	Y or N	Tuberculosis	Y or N
Asthma	Y or N	Anemia	Y or N	Radiation Therapy	Y or N
Low Blood Pressure	Y or N	Emphysema	Y or N	Glaucoma	Y or N
Epilepsy/Convulsions	Y or N	Cancer	Y or N	Recent Weight Loss	Y or N
Leukemia	Y or N	Type: _____		Liver Disease	Y or N
Diabetes	Y or N	Arthritis	Y or N	Heart Trouble	Y or N
Kidney Disease	Y or N	Joint Replacement or		Respiratory Problems	Y or N
AIDS or HIV	Y or N	Implant	Y or N	Mitral Valve Prolapse	Y or N
Thyroid Problem	Y or N	Type: _____		Ulcers	Y or N
Hepatitis	Y or N	Mouth Sores	Y or N		
Type: _____		Stomach Troubles	Y or N		

Other: _____

Dental History:

Date of Last Dental Exam: _____

Do your gums bleed while brushing or flossing?	Y or N	Do you have frequent headaches?	Y or N
Are your teeth sensitive to hot or cold liquid foods? Are your teeth sensitive to sweet liquids/foods?	Y or N	Do you grind or clinch your teeth?	Y or N
	Y or N	Do you bite your lips or cheeks?	Y or N
Do you feel pain in any of your teeth?	Y or N	Have you ever had any prolonged bleeding following extractions?	Y or N
Do you have sores or lumps in your mouth?	Y or N	Have you have Orthodontic treatment?	Y or N
Have you had any head, neck or jaw injuries?	Y or N	Do you wear dentures/partials?	Y or N
Do you have difficulty in chewing	Y or N	If yes, date of replacement _____	
Do you have clicking in your jaw	Y or N		
Pain (Joint, Ear, Side of Face)	Y or N		
Difficulty in opening or closing	Y or N		

Where do you have trouble flossing? _____ Are you happy with your smile? _____

I certify that the above questions have been answered accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

X_____ X_____

Signature of Patient or Responsible Party & Date

Signature of Attending Physican & Date