Citrus DENTAL

5935 US-27 North, #103 | Sebring, FL 33870
Phone: (863)382-0888 | Fax: (863)382-6199

New Patient Form

Name _____ Date _____
First M Last
Address _____ City _____ State _____ Zip _____
Cell # _____ Home Phone _____ Soc. Security # _____
Email _____
Check Appropriate Box
Whom may we thank for referring you? _____
Person to contact in case of an emergency/phone number _____
Driver's License # _____

Medical History

Physician's Name _____ Date of last visit _____ Reason _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following.

AIDS/HIV	Yes	No	Fainting/Dizziness	Yes	No	Scarlet Fever	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Shortness of Breath	Yes	No
Arthritis, Rheumatic	Yes	No	Headaches	Yes	No	Sinus Trouble	Yes	No
Artificial Heart Valve	Yes	No	Hepatitis__	Yes	No	Skin Rash	Yes	No
Asthma	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Back Problems	Yes	No	High Blood Pressure	Yes	No	Swollen Neck Glands	Yes	No
Bleeding Abnormally	Yes	No	Jaundice	Yes	No	Thyroid Problems	Yes	No
Blood Disease	Yes	No	Jaw Pain	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Kidney Disease	Yes	No	Tumor	Yes	No
Chemical Dependency	Yes	No	Liver Disease	Yes	No	Ulcer	Yes	No
Circulatory Problems	Yes	No	Low Blood Pressure	Yes	No	Venereal Disease	Yes	No
Congenital Heart Lesion	Yes	No	Mitral Valvule Prolapse	Yes	No	Weight Loss- Explain	Yes	No
Cortisone Treatment	Yes	No	Nervous Problem	Yes	No			
Cough, Persistent/Bloody	Yes	No	Pacemaker	Yes	No			
Diabetes	Yes	No	Psychiatric Care	Yes	No			
Drug use	Yes	No	Radiation Treatment	Yes	No			
Emphysema	Yes	No	Respiratory Disease	Yes	No			
Epilepsy	Yes	No	Rheumatic Fever	Yes	No			
For women:								
Are you nursing?	Yes	No	Take BCP?	Yes	No			
Are you pregnant?	Yes	No						
Due Date: _____								

Allergies: _____
Please list any other conditions not listed: _____
Medications: List the medications you are currently taking, dosage, and reason:
_____

Hospitalization: _____

Authorization:

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge. I also acknowledge full responsibility for the payment of such services and agree to pay in full at the time of service. I acknowledge this is my responsibility and not an insurance company to pay for all or any services. Any outstanding balance after 30 days may incur a financial charge.

X_____ **Date**: _____
Patient, Parent or Guardian (must be 18 or older)

Notice of Privacy Practices

I have been offered a copy of Citrus Dental, PA Privacy Policies.

X_____ **Date**: _____

Insurance Information

By signing below, I, the subscriber (or my dependent), verify insurance coverage and release all benefits, if any, otherwise payable to me for services rendered. I hereby authorize the release of necessary information to secure payment benefits. I accept responsibility for all accounts to be paid in full 60 days from the date of service of insurance coverage.

X_____ **Date**: _____