WE CARE DENTAL FL

WELCOME NEW PATIENT

Name				**Date of Birth**	
Preferred name				**SSN**	
Address					
City		**State**		**ZIP**	
Mobile Phone		**Home phone**			
Email					

Sex:	**Please check appropriate box:**
_____ Male _____ Female _____ Unspecified	_____ Minor _____ Single _____ Married/Partner

Emergency Contact			
Person to contact in case of emergency			
Relationship		**Phone number**	

Insurance Financial Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above and assign directly to We Care Dental Florida all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible party	
Print name	
Date	

Dental History

Previous dentist		**Date of last dental visit**	
How happy are you with your smile?		**Date of dental x-rays**	
Reason for visit today			

How often do you...			
brush your teeth?		**Floss?**	

Please check all that apply to you:

Pain in jaw/TMJ	☐	**Clicking or popping in your jaw?**	☐	**Teeth grinding/ clenching**	☐	**Sensitive teeth**	☐
Bleeding gums	☐	**Broken/Loose teeth**	☐	**Mouth Sores**	☐	**Difficulty chewing/ swallowing**	☐

Do you require pre-medication before dental procedures?	☐	**Yes**	☐	**No**
Have you ever been treated for periodontal (gum) disease?	☐	**Yes**	☐	**No**
Have you ever had Novocaine or other local anesthetic?	☐	**Yes**	☐	**No**
Are you currently wearing Dentures?	☐	**Yes**	☐	**No**

Age of dentures: _____

Pharmacy

Pharmacy name	
Phone	

(optional)

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information.

Signature of Responsible party	
Print name	
Date	

Patient Medical History

Physician_____ Office Phone_____Date of Last Exam_____

Are you under a physician's care now?	☐ Yes ☐ No	If yes, please explain:_____
Have you ever been hospitalized?	☐ Yes ☐ No	If yes, please explain:_____
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	Please list drugs:_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	
Are you on a special diet?	☐ Yes ☐ No	
Do you use tobacco?	☐ Yes ☐ No	
Do you use controlled substances?	☐ Yes ☐ No	

Women: Are you:

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain:_____

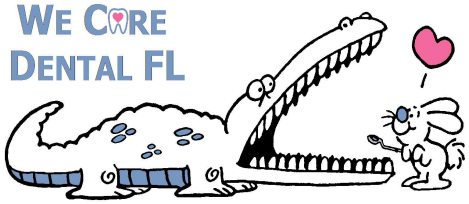
Do you have, or have you had, any of the following?

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

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 of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____DATE_____

WE CARE DENTAL FL



Dr. B. Linda Ongley, D.M.D.

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to

Name of recipient	
Relationship	

I give authorization to disclose the following information:

☐ **all treatment information.**

☐ **information specifically related to these treatment dates.**

_____ **Start date** _____ **End Date**

Signature	
Date	

Notice of Privacy Practices (must be signed by ALL new patients)

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature	
Date	