Dental Registration & Health History

Cape Coral Dentistry (239) 574-3383
16 Del Prado Blvd S Cape Coral, FL 33990

Date _____

Patient Information

Patient Name _____ Date of Birth _____

Home Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email Address _____

Employer _____ Occupation _____

Employer Address _____ Work Phone _____

Name(s) of Spouse and/or Children _____

Primary Insurance

Policy Holder _____

Relation to Patient _____Birthdate _____ SSN _____

Address (if different than patient)_____ Phone _____

Insurance Company _____ Employer _____

Group ID _____ Subscriber/Member ID _____

Other Dependents on Plan _____

Secondary Insurance (if applicable)

Insurance Company _____ Employer _____

Group ID _____ Subscriber/Member ID _____

Emergency Contact

Name _____Relation _____ Phone _____

Who may we thank for referring you to our office? _____

All of the above information is correct. **Signature** _____ **Date** _____

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Medical Health History

Who is your physician? _____

Physician's Phone Number _____ Physician's City and State _____

Last physical exam? _____Are you being treated for anything now?_____

If yes, please describe _____

Recent Surgery? _____

Do you have or did you ever have: ⬜High Blood Pressure ⬜Thyroid (high/low) ⬜High Cholesterol ⬜Anemia ⬜Liver Disease ⬜Hepatitis (type_____) ⬜AIDS or HIV ⬜Asthma ⬜Epilepsy/Convulsions ⬜Cold Sores ⬜Kidney Disease ⬜Murmur/MVP ⬜Tuberculosis ⬜Heart Issues ⬜Other_____

Diabetes: ⬜Type I ⬜Type II Last HAIC: _____ Blood Pressure: ⬜High ⬜Low Last Reading: _____

Have you ever had: Joint replacement surgery? _____ Heart valve replacement? _____

Does your doctor want you to premedicate before dental appointments? _____

Allergies: ⬜Penicillin ⬜Sulfa Drugs ⬜Codeine ⬜Acrylic ⬜Latex ⬜Other_____

Are you subject to prolonged bleeding? _____ Do you become "out of breath" easily? _____

Have you had or are you having chemotherapy or radiation treatment? _____

Do you smoke or chew tobacco? ⬜Yes ⬜No If yes, describe frequency? _____

Do you take aspirin regularly? ⬜Yes ⬜No If yes, describe frequency? _____

If female: Are you pregnant? _____ Due date? _____

Current Medications, Vitamins and/or Supplements (please let us know if you need more space):

Medication Name	Dossage	Purpose

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Dental Health History

Date of last dental exam: _____ Date of last dental cleaning: _____

How often do you brush your teeth?_____ Floss? _____

How often do you typically get your teeth cleaned? _____

What concerns you about your dental health? _____

Do you have any pain in your teeth because of heat, cold or sweets? ⬜ Yes ⬜ No

If yes, please explain: _____

Do you have pain in any part of the mouth while biting and/or chewing? ⬜ Yes ⬜ No

If yes, please explain: _____

Do your gums ever bleed while chewing, brushing or flossing? ⬜ Yes ⬜ No

If yes, please explain: _____

Do you clench your teeth during the day or night? ⬜ Yes ⬜ No

If yes, please explain: _____

Have you ever had gum surgery or been told you need to? ⬜ Yes ⬜ No

If yes, please explain: _____

Are you completely happy with the appearance of your teeth? ⬜ Yes ⬜ No

If no, please explain: _____

Do you have all your teeth (other than wisdom teeth)? ⬜ Yes ⬜ No

If not, did you replace any teeth? _____

Do you lose fillings or break fillings often? ⬜ Yes ⬜ No

If yes, please explain: _____

All of the above information is correct. **Signature** _____ **Date** _____

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

The undersigned acknowledges a copy of the currently effective Notice of Privacy Practices has been made available to me for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____ _____
Please **PRINT** your name Please **SIGN** your name Date

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name: _____ Phone:_____Relationship: _____

Name: _____ Phone:_____Relationship: _____

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, consent to the dental and oral surgical procedures agreed to by myself (or guardian) and the dentist to be necessary or advisable, including the use of local anesthetic and radiographs as indicated. I understand that I am responsible for payment for all treatment rendered. I grant the dentist the right to release health information obtained from me and information about my dental treatment to health practitioners in emergency situations.

_____ _____ _____
Please **PRINT** your name Please **SIGN** your name Date

RELATED INFORMATION

1. Payment is due at the time of service. Acceptable forms of payments include cash, check or credit card (Visa, Mastercard, Discover and American Express). Third party financing is accepted in the form of Care Credit.
2. Balances older than 30 days may be subject to additional collection fees and interest charges of 2% per month or 18% annually. Returned checks will be assessed additional fees and will be turned over to the county attorney's office for collection if not paid timely.
3. In the event the account is not paid, and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs, and collection agency fees).
4. Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. 24-hour notice is needed to avoid a charge.
5. As a courtesy to you we will help you process your insurance claims. We are not a Medicare or Medicaid provider and cannot file claims to either. Please understand that we will provide an estimate to you, but it is not a guarantee of payment. If your insurance company has not made payment within 60 days, we ask that you contact your insurance company for payment. If payment is not received or your claim is denied, you will be responsible for the full amount at that time.

I have read and I understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

_____ _____ _____
Please **PRINT** your name Please **SIGN** your name Date