DENTAL CARE
of Van Dyke 18930 N Dale Mabry Hwy Suite 102 • Lutz, FL 33548 • O 813.528.8701 • F 813.528.8703

PATIENT REGISTRATION

Patient Information

SECTION 1

First Name:_____ Last Name:_____ M.I.:_____

Address:_____ Suite/Unit/Apt #:_____

City, State, Zip:_____ Home Phone:_____

Work Phone:_____ Ext:_____ Mobile:_____ Pager:_____

Date of Birth:_____ Social Sec.#:_____ Drivers Lic.#:_____

E-mail Address:_____

Whom may we thank for referring you?:_____

SECTION 2

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Child

Employer Name:_____

Employer Address:_____ Employer Phone #:_____

Preferred Pharmacy:_____ Pharmacy Phone #:_____

Emergency Contact (Name & Number):_____

Responsible Party
(if someone other than patient)

☐ Same as Above

First Name:_____ Last Name:_____ M.I.:_____

Address:_____ Suite/Unit/Apt #:_____

City, State, Zip:_____ Home Phone:_____

Work Phone:_____ Ext:_____ Mobile:_____ Pager:_____

Date of Birth:_____ Social Sec.#:_____ Drivers Lic.#:_____

E-mail Address:_____

☐ Responsible Party is also Policy Holder for Patient ☐ Primary Insurance Holder ☐ Secondary Insurance Holder

Primary Insurance Information

Name of Insured:_____ Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Sec. No.:_____ Insured Date of Birth:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

City, State, Zip:_____ City, State, Zip:_____

Secondary Insurance Information

Name of Insured:_____ Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Sec. No.:_____ Insured Date of Birth:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

City, State, Zip:_____ City, State, Zip:_____

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MEDICAL HISTORY

Health Notice

Although dental personnel primarily treat the area in and around your mouth, this area of your body is an important part of your overall health and well-being. Health problems that you may have, or medication that you may be taking, could have an interrelationship with dentistry that may not be obvious. Please be mindful of this fact while completing the following questions. This information is kept strictly confidential. Thank you in advance.

General Health Questions

Are you under a physician's care now? Yes ☐ No ☐ Name: _____

Phone #: _____

Have you even been hospitalized or had a major operation? Yes ☐ No ☐ If yes, explain: _____

Have you ever had a serious head or neck injury? Yes ☐ No ☐ If yes, explain: _____

Are you taking any medications, pills, or drugs? Yes ☐ No ☐ If yes, explain: _____

Do you take, or have you taken Phen-Fen or Redux? Yes ☐ No ☐ If yes, when: _____

Are you on a special diet? Yes ☐ No ☐ If yes, explain: _____

Do you use tobacco? Yes ☐ No ☐

Do you use controlled substances? Yes ☐ No ☐

WOMEN are you... ☐ Pregnant? ☐ Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Allergies

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfur Drugs

☐ Other (explain): _____

Medical Conditions

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

- ☐ AIDS / HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis / Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores / Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells / Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack / Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble / Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach / Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Veneral Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? _____

Please explain: _____

Comments

_____

_____

_____

Signature

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 the 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: _____

HIPPA PATIENT QUESTIONAIRE

1. Please List the family members or other person(s), if any whom we may inform about your general medical/dental condition and your diagnosis (including treatment, payment and health care information):

Name: _____Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____Phone Number: _____

2. Please list the family members or others, if any we may inform about your dental /medical conditions **ONLY IN A EMERGENCY**

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

3. Please print the address of where you would like your billing statements and /or correspondence from our office to be sent .

Name: _____ Address: _____

4. Please indicate if you want all correspondence from us sent in a sealed envelope marked "Confidential". YES ___ NO ___

5. Please print the telephone number or e-mail where you want to receive calls about your appointments, lab and x-ray results or other health care information.

Number : _____ E-Mail :_____

6. Can confidential messages (ie., appointment reminders) be left on your telephone answering machine or voicemail? Yes ____ No ___

7. I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule 2013.

Patient Name : _____ (guardian if under 18 years)

Patient/ Guardian Signature _____ Date : _____

Broken Appointment Policy

We make every effort to schedule appointments that are the most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

At Dental Care of Van Dyke, we consider a broken appointment to be:

- A cancellation with less than 48 hours notice
- When a patient does not show up for their appointment
- When a patient shows up 15 minutes past the appointment time

Because appointments are not double-booked, we require that you provide notice of cancellation at least 48 hours prior to your scheduled appointment time. For any missed appointment a fee of $50 dollars will be assessed to your account.

This fee covers the cost of office overhead during time set aside specifically for you or for your dependent(s). Patients arriving more than 15 minutes late for an appointment may need to be rescheduled, as there may not be adequate time to complete your procedure(s).

Please call ahead if you are running late. PLEASE RETAIN THIS STATEMENT FOR FUTURE REFERENCE. IF YOU DO NOT UNDERSTAND THE POLICIES SET FORTH PLEASE ASK FOR AN EXPLANATION. WE WILL BE HAPPY TO DISCUSS YOUR CONCERNS.

Print Name: _____

Signature : _____ Date : _____

DENTAL CARE OF VAN DYKE
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PLEASE TAKE A FEW MOMENTS TO TELL US ABOUT YOUR SMILE

NAME_____ DATE_____

Have you thought about improving the appearance of your smile? YES/NO

Would you like to straighten your teeth? YES/NO

Do you have spaces that you don't like? YES/NO

Would you like to change the color of your teeth? YES/NO

Are your teeth chipped? YES/NO

Are your teeth wearing on the biting surface? YES/NO

What would you change about your teeth? (Circle all that apply)

COLOR SHAPE SIZE STRAIGHTEN OTHER_____

Have you had orthodontic work in the past? When _____ YES/NO

Are you aware that most dental insurance plans cover orthodontic treatments which include clear aligners? YES/NO

Have you confirmed your dental insurance coverage for orthodontic treatment, including clear aligners? YES/NO