

# Dental Registration & Health History

Independent Dental Care (239) 437-8900  
9131 College Pkwy Unit 150 Ft Myers, FL 33919

## Patient Information

Date \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Preferred Name \_\_\_\_\_  Female  Male

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Name(s) of Spouse and/or Children \_\_\_\_\_

Referred By \_\_\_\_\_ Full time resident?  Yes  No

## Primary Insurance

Insurance Company \_\_\_\_\_ Employer \_\_\_\_\_

Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Group ID \_\_\_\_\_ Subscriber/Member ID \_\_\_\_\_

Address (if different than patient) \_\_\_\_\_ Phone \_\_\_\_\_

## Emergency Contact

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

## Pharmacy Information:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

## DENTAL HEALTH HISTORY

Last dental visit \_\_\_\_\_ Last dental cleaning \_\_\_\_\_ Last dental x-rays \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Location \_\_\_\_\_

Reason for your visit \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_

Do you have missing teeth?  Yes  No Are you interested in replacing them?  Yes  No

Have you ever been treated for periodontal disease?  Yes  No Date \_\_\_\_\_

Have you ever had orthodontic braces?  Yes  No Date \_\_\_\_\_

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## 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

## 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: \_\_\_\_\_

## **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 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

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### COMMUNICATION CONSENT FORM

- I consent to Independent Dental Care contacting me electronically by the **email address and/or cell phone** below for the purpose of receiving appointment reminders, notification that I need to make an appointment, dental records, survey regarding dental visit, or reminders of uncompleted treatment.
- I understand that during the transmission of these messages, the information contained at one point or another may pass through a public network and onto a personal electronic device and as such the transmission may not be secure. However, the practice will not transmit any personal or confidential information about your health, procedures or account status without your permission. (Please note that email messages from our office are encrypted if the message contains any personal health information).
- I agree to inform the practice if my email address or cell phone number changes. I understand and acknowledge that I can cancel this consent at any time.
- Do you give us permission to leave messages on these devices, such as appointment times, pre-treatment estimate amounts, pre-medication reminders (if applicable)

Email  Yes  No

Text Messaging  Yes  No

\_\_\_\_\_  
E-mail Address

\_\_\_\_\_  
Cell Phone Number

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

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Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date \_\_\_\_\_

Are you under a physician's care?  Yes  No

Are you currently being treated for anything? \_\_\_\_\_

Physicians Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No

If yes \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No

If yes \_\_\_\_\_

Are you taking any medication, pills, or drugs?  Yes  No

List all current medications (please let us know if you need more space)

Medication Name	Dosage	Purpose

Do you take, or have you taken, Phen-fen or Redux?  Yes  No

If yes \_\_\_\_\_

Have you ever taken Fosamax, Boniva, AcetoneI or any other bisphosphonates?  Yes  No

If yes \_\_\_\_\_

Are you on a special diet?  Yes  No Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

If yes \_\_\_\_\_

Female: Are you  Pregnant/Trying to get pregnant  Nursing  Taking oral contraceptives

Do you have any allergies to medications?  Yes  No

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Meta  Latex

Sulfa Drugs  Epinephrine  Other \_\_\_\_\_

If yes \_\_\_\_\_

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**Do you have, or have you had, any of the following? Please check YES or NO**

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

**Have you ever had any serious illness not listed above?**  Yes  No If yes, \_\_\_\_\_

**Do you need to premedicate before dental appointments?**  Yes  No If yes, \_\_\_\_\_

Additional Comments:

**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 health. It is my responsibility to inform the dental office of any changes in medical status.**

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date