



Personal Identification-

Last Name: _____ First Name: _____ Middle: _____

Name you prefer to be called: _____ Title: Mr. Mrs. Miss. Other: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Home Phone: (_____) _____ Year-Round Resident: Yes No

Work Phone: (_____) _____ Cell Phone: (_____) _____

I prefer to be contacted at my: Home number Work number Cell number

Email: _____

May we text/email you about upcoming appointments: Yes No

Gender: Male Female Marital Status: Divorced Married Single Separated Widowed

Birth date: _____ Soc. Sec. #: (only if you have insurance) _____

Party Responsible for Payment: Self Spouse Parent Caregiver

Other _____

Name of Responsible Party: _____ Signature: _____

Who referred you to our office? _____

Insurance Information

Dental Insurance Company (if applicable): _____ Group/ID #: _____

Address: _____ Phone: (_____) _____

Subscriber: Self Spouse Parent Other Subscriber Name: _____ DOB: _____

SS#: _____

We are a fee for service practice. Payment is due at time of service unless other arrangements are made. We will provide all necessary dental forms needed to help you obtain reimbursement from your dental insurance company.

Employment Status

Employer (School if student): _____ Title (Major if student): _____

Employer/School Address: _____

Emergency Contact Information

Emergency Contact Name: _____ Relationship: _____
Emergency Contact Phone Number: (_____) _____

Medical Information

Primary Care Physician's Name: _____ Phone: (_____) _____

Are you under a physician's care now? Yes No

Reason: _____

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

Please list any medications you are currently taking:

Medication	Reason	Medication	Reason

Do you use tobacco? Yes No Type: _____ Are you currently pregnant? Yes No

Do you have any known allergies? Aspirin Penicillin Codeine Latex Sulfa

Other _____

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

- AIDS/HIV Positive
- Alzheimer's Disease
- Anemia
- Angina
- Artificial Heart Valve
- Artificial Joint
- Cancer
- Chemotherapy
- Cold Sores/Fever Blisters
- Congenital Heart Disorder
- Diabetes
- Emphysema
- Epilepsy/Seizures
- Excessive Bleeding
- Fainting Spells
- Frequent Headaches
- Glaucoma
- Hay Fever
- Heart Attack/Failure
- Heart Murmur
- Heart Pacemaker
- Heart Trouble/Disease
- Hepatitis A
- Hepatitis B
- Herpes
- High Blood Pressure
- Hypoglycemia
- Irregular Heartbeat
- Kidney Problems
- Liver Disease
- Mitral Valve Prolapse
- Pain in Jaw Joints
- Radiation Treatment
- Rheumatic Fever
- Scarlet Fever
- Sinus Trouble
- Tuberculosis
- Yellow Jaundice
- Hepatitis C
- Sleep Apnea

Have you had any serious illness not listed above? _____

Do you require a premedication prior to dental appointments: Yes No Reason: _____

Prescribing Doctor: _____ Phone: (_____) _____

Type prescribed: _____ Dosage: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

Do you see another dentist for cleanings? Dentist: _____ Frequency: _____

Patient Signature: _____ Date: _____



Appointment Change and Cancellation Policy

Appointments are considered confirmed when they are made. Our office requires two business days notice for appointment change requests. This includes requests for changes in time, date, treatment, provider, or appointment cancellation. Please note that should you leave a request for change on our voicemail when the office is closed, we will consider the request to have been made on the following business day.

Should you fail to give the required two business days notice for appointment changes, you will be charged a fee. This fee could be up to and including the full fee for the appointment you changed, cancelled, or missed.

I have read and understand the Appointment Change and Cancellation Policy.

Sign

Date



Informed Consent and Treatment Confirmation

Patient's Name: _____ Date _____

To my knowledge I have given an accurate report of my health history. Any prior allergic or unusual reactions, gum or skin reactions, abnormal bleeding and any other conditions related to my health are included.

I have been informed and understand that occasionally there are complications from treatment and local anesthesia. Complications can include but are not limited to: pain, swelling, sensitivity, gum discoloration, bruising, infection, drug/anesthetic reactions and side effects, damage to adjacent teeth or fillings, post-treatment bleeding, failure of the dental treatment procedure necessitating additional treatment, and complications during treatment necessitating referral to a specialist.

I understand that photos, radiographs, and other records may be made during the course of my examination, treatment and follow-up care. I give my permission for such items to be used for purposes of education, research, or publication in professional journals or websites. I understand my identity will not be revealed (by name). Please indicate if no full facial photos may be used during educational programs by checking here.

Vero Beach Art of Dentistry has my consent to provide treatment for conditions that the doctor deems necessary.

Signed _____ Date _____

Relationship if patient is a minor: _____

Witness _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

I have reviewed this office's Notice of Privacy Practices which describes how my health information may be used or disclosed.

*A copy is available upon request.

Print Name

Signature

Date

May we confirmed or leave messages concerning your appointments / treatment:

At home _____ At work _____ On your cell _____

Is there anyone with whom you would allow us to share your personal information or leave messages?

Who: _____

Relationship: _____

For office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (specify) _____