GENERAL INFORMATION

Today's Date: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Last Name: _____

Mailing Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Cell Phone: _____ Email: _____

Home Phone: _____ Work Phone: _____

What is your preferred phone number?
Select one.
☐ Cell Phone
☐ Home Phone
☐ Work Phone

How do you want to be contacted for confirming your appointments?
Check all that apply.
☐ Email
☐ Texting
☐ Phone Call

Sex: ☐ M ☐ F ☐ Prefer not to say. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Birthdate: _____ Social Security Number: _____
MM/DD/YYY *XXX-XX-XXXX*

Occupation: _____ Employer: _____

IN CASE OF EMERGECNY PLEASE CONTACT

Emergency Contact Name: _____ Phone: _____

Relation to Patient: _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company: _____ Group Number: _____

Policy Owner's Name: _____ Policy Owner's Birthdate: _____

Relation to Patient: _____ Policy Owner's SSN: _____

Is the Patient covered by additional insurance?: ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature *Relationship* *Date*

DENTAL HISTORY

Reason for today's visit: _____

_____

_____

Former Dentist Name: _____ City/State of Former Dentist: _____

Date of last dental visit: _____ Date of last dental X-rays: _____

How often do you floss per week?: _____ How often do you brush per week?: _____

What type of bristles do you use?: ☐ Hard ☐ Medium ☐ Soft Are you happy with your smile?: ☐ Yes ☐ No

Have you ever had a serious or difficult problem associated with previous dental work?: ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Please mark (X) to any of the following conditions that apply to you:

Appearance
- ☐ Crooked teeth
- ☐ Discolored teeth
- ☐ Flat teeth
- ☐ Misshaped teeth
- ☐ Overbite
- ☐ Spaces
- ☐ Worn teeth

Pain/Discomfort
- ☐ Burning sensation on tongue
- ☐ Broken teeth/fillings
- ☐ Dry mouth
- ☐ Pain around ear
- ☐ Pressure
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth
- ☐ Worn teeth

Function
- ☐ Bad Bite
- ☐ Difficulty chewing on either side
- ☐ Difficulty opening or closing
- ☐ Food collection between teeth
- ☐ Grinding/Clenching
- ☐ Headaches
- ☐ Jaw Joint pain (TMJ)
- ☐ Jaw Joint (TMJ) clicking/popping
- ☐ Mouth breathing
- ☐ Speech impediment
- ☐ Sore muscles (neck, shoulders)

Periodontal (Gum) Health
- ☐ Bad Breath
- ☐ Bleeding, Swollen, Irritated gums
- ☐ Loose tipped, shifting teeth
- ☐ Previous perio/gum disease

Habits
- ☐ Thumb-sucking
- ☐ Nail-biting
- ☐ Check/lip biting
- ☐ Chewing on ice/foreign objects

Sleep Pattern or Conditions
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Daytime Drowsiness

Social
- ☐ Tobacco use

How much per day: _____
For how long: _____
- ☐ Alcohol consumption

Number of drinks per week: _____
- ☐ Drugs

Frequency per week: _____

I give authorization to you or your assignee to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by you or your assignee to make a thorough diagnosis of the patient's dental needs. I also authorize you or your assignee to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

_____ _____ _____

Patient or Legal Guardian Signature *Print Name* *Date*

MEDICAL HISTORY

ORANGE PARK Smiles
DOUGLAS M. REED D.D.S.

Are you under the care of a physician? ☐ Yes ☐ No
If no, please explain: _____

Physician's Name: _____ Date of last visit: _____

Please mark (X) to any of the following conditions that apply to you:

Cancer
Type _____
☐ Chemotherapy
☐ Radiation Therapy

Cardiovascular
☐ Angina (chest pain)
☐ Artificial heart valve
☐ Heart conditions
☐ Heart murmur
☐ Heart surgery
☐ High blood pressure
☐ Low blood pressure
☐ Mitral valve prolapse
☐ Pacemaker
☐ Rheumatic fever
☐ Scarlet fever
☐ Atrial fib/flutter (irregular heart rhythm)

Endocrinology
☐ Diabetes
☐ Hepatitis A/B/C
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Thyroid Disease

Gastrointestinal
☐ Ulcers (stomach)
☐ Gastrointestinal disease

Hematologic/Lymphatic
☐ Anemia
☐ Blood disorders
☐ Bruise easily
☐ Excessive bleeding

Musculoskeletal
☐ Arthritis
☐ Artificial joints
☐ Back problems
☐ Jaw joint pain
☐ Rheumatoid Arthritis
☐ Osteoporosis

Neurological
☐ Anxiety
☐ Depression
☐ Dizziness
☐ Drug/Alcohol addiction
☐ Fainting
☐ Seizures
☐ Psychiatric illness
☐ Stroke

Respiratory
☐ Asthma
☐ Emphysema
☐ Respiratory problems
☐ Sinus problems
☐ Sleep Apnea
☐ Tuberculosis

Viral Infections
☐ AIDS
☐ HIV Positive
☐ HPV

Women
☐ Currently pregnant
☐ Nursing
☐ Using birth control

Other
☐ Ulcer
☐ Swollen feet or ankles
☐ Swollen neck glands
☐ Tonsillitis
☐ Tumor or growth on head or neck
☐ Unexplained weight loss
☐ _____

Are you taking or have you recently taken any prescription or over the counter medicines? ☐ Yes ☐ No
If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements: _____

Are you taking or have you recently taken anticoagulant (blood thinners)? ☐ Yes ☐ No
If yes, please list why and the name of the medication(s): _____

ALLERGIES
☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ Other: _____
☐ Barbiturates (sleeping pills) ☐ Iodine ☐ Local Anesthetic ☐ Sulfa

PHARMACY
Pharmacy name: _____ **Pharmacy phone number:** _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on the form is accurate. I understand the importance of a truthful health history and that my dentist and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of the staff, responsible for any action they do or do not take because of errors or omissions that I may have made in the completion of the form.

_____ _____ _____
Patient or Legal Guardian Signature *Print Name* *Date*

CONSENT FOR SERVICES

In order to receive treatment at this office, it is necessary to make financial arrangements in advance. Our practice relies on reimbursement from patients to cover the costs incurred in their care, and therefore, each patient's financial responsibility must be determined prior to treatment.

Please note that all emergency dental services or any dental services performed without previous financial arrangements must be paid for in cash or by credit card at the time the services are performed.

For all accounts exceeding 30 days without prior written financial arrangements, a late charge of $20.00 or 1 ½ % per month (18% annum) on the unpaid balance will be applied. I understand that the fee estimate provided for this dental care is valid for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the doctor, I agree to pay the value of said services to the doctor at the time the services are rendered or within five (5) days of receiving the bill. I also agree that if legal action is taken or if a collection agency is used, I will be responsible for all attorney fees or collection fees.

I understand that I may be charged a $50 cancellation fee for any appointments that are canceled or changed within 24 hours of the original scheduled date.

I authorize you or your assignee to contact me at the phone number(s) or email address(s) provided in order to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to the content.

Signature of Patient, Parent or Guardian	*Relation to Patient*	*Date*
Signature of Guarantor of Payment / Responsible person	*Relation to Patient*	*Date*

NOTICE OF PRIVACY SERVICES

This notice provides information about how your medical information may be used and disclosed, as well as how you can access this information. Please read it carefully.

Our office is obligated by law to maintain the privacy and confidentiality of your protected health information and to inform our patients about our legal privacy practices concerning their health information.

Treatment:
In order to facilitate your treatment, payment, or healthcare operations, we may disclose your healthcare information to other healthcare professionals outside of our practice. For instance, if you require a specialist's consultation for your condition, if Dr. Reed is unavailable and another dental practitioner is providing coverage, or in the case of a medical emergency.

Payment:
To obtain payment for the services provided to you or for services related to your dental health, we may disclose your health information to your insurance company. As a courtesy, we submit itemized billing statements to your insurance carrier. In certain cases, the insurance company may require additional supporting information, such as diagnosis, procedure dates, and details of prior care.

Public Health:
As required by law, we may disclose your health information to public health authorities in reference to disease control and prevention, injury or disability, abuse or neglect, use of medications and reactions to medications, and infection exposure.

I, (Print Name) _____ have had an opportunity to read and consider the contents of this office's privacy practices. I understand that by signing this consent form, I am giving my consent to Douglas Reed, D.D.S. and his staff to disclose my health care information as described above.

_____	_____	_____
Signature of Patient, Parent or Guardian	*Print Signed Name*	*Date*

Please list any additional individuals whom you authorize us to share your healthcare information with.

_____	_____	_____
Name	*Number*	*Relation to Patient*
_____	_____	_____
Name	*Number*	*Relation to Patient*