# Juno Beach Smiles

ENHANCED SMILES. ENHANCED LIVES.

Juno Beach Professional Bldg.
13700 U.S. Hwy. 1 • Suite 201 • Juno Beach, FL 33408-1600

**GREG K. RILEY D.M.D., P.A. • DUANE E. KEUNING, D.M.D., P.A.**

## PATIENT INFORMATION

Date__________ Home Phone __________ Cell __________

Name__________ (Last Name / First / Middle) I like to be called: __________

Local Address__________ Apt / Unit #__________

City__________ State__________ Zip__________

E-mail address__________

Social Security #____-____-____ AND D.L. #__________ State_____

Sex ☐ M ☐ F Date of Birth__________ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed by __________ Occupation__________

Full Time ☐ Part Time ☐ Retired ☐ Business Phone __________ ext__________

Are you a year-round resident of Florida? Yes ☐ No ☐ If no, which months are spent in Florida?__________

In case of emergency who should be notified?__________ @ __________

Has anyone in your family ever been a patient here? No ☐ Yes ☐ Name__________

Whom may we thank for referring you?__________

Student Information F/T ☐ P/T ☐ Where?__________

## DENTAL HISTORY

Reason for Today's Visit__________

Former Dentist Name__________ Phone__________

Last Dental Appointment was__________ For__________ Date of last X-rays__________

**Check (√) if you have any of the following problems:**

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Broken or loose fillings
- ☐ Clicking or popping jaw
- ☐ Food traps between teeth
- ☐ Grinding teeth
- ☐ Jaw surgery
- ☐ Loose teeth
- ☐ Orthodontic treatment
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to pressure
- ☐ Sensitivity to sweets
- ☐ Sores or growths in mouth

Do you gag easily? Yes ☐ No ☐

Have you had any serious problems with any previous dental treatment? No ☐ Yes ☐ Explain__________

## PERMISSION/DOCTOR'S NOTES

**PERMISSION FOR TREATMENT**: This is to certify that I, the undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary, including the use of local anesthetic and X-rays as indicated. I certify that all information I have provided on this form is correct. **I will assume responsibility for fees associated with those procedures.**

__________
*Patient / Parent signature*

**(over)**

MEDICAL HISTORY

Have you had any serious illnesses or operations? Yes ❑ No ❑ If yes, describe ____________________

Have you ever had a blood transfusion? Yes ❑ No ❑ If yes, please give approximate dates ____________________

(Women) Are you pregnant? Yes ❑ No ❑ Nursing? Yes ❑ No ❑ Taking birth control pills? Yes ❑ No ❑

**Please check (√) if you have had any of the following:**

❑ AIDS
❑ Anemia
❑ Arthritis / Rheumatism
❑ Artificial Heart Valves
❑ Artificial Joints, Year ________
❑ Asthma
❑ Back Problems / Severe
❑ Blood Disease
❑ Cancer, Year ________
❑ Chemical Dependency
❑ Chemotherapy
❑ Circulatory Problems
❑ Congenital Heart Lesions
❑ Cortisone Treatments
❑ Cough Persist
❑ Cough up Blood
❑ Coumadin Therapy
❑ Diabetes
❑ Epilepsy
❑ Fainting
❑ Glaucoma
❑ Hay Fever
❑ Headaches / Migraines
❑ Heart Murmur
❑ Heart Problems
Describe ________
❑ Hemophilia
❑ Hepatitis A B C
❑ High Blood Pressure
❑ HIV Positive
❑ Jaundice
❑ Jaw Pain
❑ Kidney Disease
❑ Liver Disease
❑ Low Blood Pressure
❑ Medical Implants, Year ________
❑ Metal Allergies
❑ Mitral Valve Prolapse
❑ Nervous Problems
❑ Osteoporosis
❑ Pacemaker
❑ Psychiatric Care
❑ Radiation Treatment
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Shortness of Breath
❑ Sinus Trouble
❑ Skin Rash
❑ Stent(s), Year ________
❑ Stroke, Year ________
❑ Swelling of Feet or Ankles
❑ Thyroid Problems
❑ Tobacco / Smoking
❑ Tonsillitis
❑ Tuberculosis / Lung Disease
❑ Ulcer
❑ Venereal Disease

Do you take: ❑ Daily Aspirin ________mg ❑ Herbs ❑ Minerals ❑ Vitamins

**MEDICATION / DOSAGE**

**ALLERGIES TO MEDICATIONS**

RESPONSIBLE PARTY

**Information for Person Responsible for Account / Payments**

Name ____________________ Relationship to Patient ____________________

Birth date ____________ Social Security # ______/______/______ Phone ____________

Address (if different from Patient) ____________________ State ________ Zip ________

Person Responsible Employed by ____________________ Occupation ____________

Business Address ____________________ Phone # ____________

Insurance Company ____________________ Phone # ____________ Group # ____________

Names of other dependents covered by this plan ____________________

AUTHORIZATION

**Authorization**

**I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for service rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

Signature ____________________ Date ____________

**Payment is due at time of treatment unless prior arrangements are made.**