Juno Beach Smiles

ENHANCED SMILES. ENHANCED LIVES.

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PATIENT INFORMATION

Date_____ Home Phone _____ Cell _____

Name_____ I like to be called: _____
Last Name First Middle

Local Address_____ Apt / Unit #_____

City_____ State_____ Zip_____

E-mail address_____

Social Security #_____/_____/_____ OR 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?_____

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 will assume responsibility for fees associated with those procedures. I also certify that all information I have provided on this form is correct.

Doctor's Notes:

_____
Patient / Parent signature

_____

_____

_____

_____

_____

_____

(over)

MEDICAL HISTORY

Physician's Name_____ Phone # _____ Fax # _____

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
- ❑ Asthma
- ❑ Back Problems / Severe
- ❑ Blood Disease
- ❑ Cancer
- ❑ 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
- ❑ Metal Allergies
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus Trouble
- ❑ Skin Rash
- ❑ Stroke
- ❑ 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

_____ _____

_____ _____

_____ _____

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

Insurance Authorization

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. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date _____

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