10700 Johnson Blvd.
Ste 4
Seminole FL 33772
(727)393-1133
contemporarydentalarts1@hotmail.com

Contemporary Dental Arts

www.contemporarydentalarts.net

Welcome to Contemporary Dental Arts

Chart #.

FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: SS #. Prev. Visit:

Email Address: Best time to call:

Phone: Home Work Ext Mobile Fax Other

Address:

City State Zip Code

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: Phone:

Address:

City State Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

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Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long have you been a patient there:

Date of most recent dental exam / x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

If any conditions or alerts selected above needs further clarification, please describe below:

Name of physician and their specialty:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

List all medications, supplements, and/or vitamins taken within the last two years:

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Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Allergies
☐ Allergy - Amox	☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro
☐ Allergy - Hay Fever	☐ Allergy - Latex	☐ Allergy - Metal	☐ Allergy - Other
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Aspirin - Daily 81mg	☐ Aspirin - Daily	☐ Asthma
☐ Blood Disease	☐ Blood Thinner	☐ Cancer	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ Fosamax	☐ Glaucoma	☐ Head Injuries	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ Herpes	☐ High Blood Pressure
☐ HIV	☐ Jaundice	☐ Kidney Disease	☐ Liver Disease
☐ Mental Disorders	☐ Nervous Disorders	☐ No Epi	☐ Other _____
☐ Pacemaker	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

☐ Ever been hospitalized (illness or injury)	☐ Presently being treated for any other illnesses
☐ Taking medication for weight control (ie fen-phen)	☐ Taking dietary supplements
☐ Subject to frequent headaches	☐ A smoker or smoked previously
☐ FEMALE: Taking birth control pills	☐ FEMALE: Pregnant

* ☐ By checking this box, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

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Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance.The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that we will estimate the out of pocket expense to you based on the benefits given to us from your insruance company. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me by this practice, I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.

Primary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Company Name and Phone Number:

_____

Insurance Subscriber ID # and Date of Birth

_____

Insurance Authorization:

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic 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 changes whether or not paid by insurance.

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HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form,

☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Patient/Responsible Party Signature & date

Signature: _____ Date:

Provider Signature & date

Signature: _____ Date:

Response Date: