Seven Springs
DENTAL
EXCELLENCE

Patient Information

Name_____ Date of Birth _____

Social Security Number_____ Driver's License # _____

Address_____City_____State_____Zip Code_____

Cell #_____Home #_____EMAIL_____

Circle Appropriate Choice: Minor Single Married Divorce Widowed Separated

Spouse or Parent/Guardian's Name _____ Cell # _____

Emergency Contact _____ Phone #_____ Relationship to Patient _____

Name of other Person Responsible for the Account _____Relationship to Patient _____

Address_____City_____State_____Zip Code_____

Cell #_____Home #_____EMAIL_____

Whom may we thank for referring you? _____

Patient Dental History

Previous Dentist_____ Phone # _____ Last Exam_____

Do your gums bleed while you brush or floss? _____

Are your teeth sensitive to sweets, hot or cold liquids or foods? _____

Do you feel pain or discomfort to any of your teeth? _____

Have you had any head, neck or jaw injuries? _____

Have you experienced any of the following problems in your jaw? (Please Circle) Clicking Pain in the joint Ear Side of face

Have you had any Periodontal Gum Treatments, Deep Cleanings? _____

Do you clench or grind your teeth? _____

Do you get frequent headaches? _____

Do you bite your cheek or lip frequently? _____

Have you had any difficult extractions in the past or prolonged bleeding from an extraction? _____

Have you had orthodontic treatment (braces)? If so when? _____

Do you wear dentures or partials? If yes, date of placement _____

Patient Medical History

Physician_____ Office #_____ Last Exam_____

Specialist_____ Office #_____ Last Exam_____

Specialist_____ Office #_____ Last Exam_____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? _____

Do you have any allergies to Medications/Antibiotics/Sulfa Drugs/Local Anesthetics/Seasonal/Latex? _____

_____

Are you taking any medication(s) including non-prescription? _____

_____

Have you taken Cialis, Viagra, Levitra, Stendra, Staxyn, Sildenafil, Avanafil, Tadalafil, or Vardenafil in the last 24 hours? _____

Do you see someone for pain management care or use a controlled substance? _____

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? _____

Do you have or have you had any of the following? Check YES or NO

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Nervous Disorder			Artificial Joint		
Low Blood Pressure			Hemorrhagic Stroke			Revised Artificial Joint		
Heart Disease			Liver Disease			Artificial Heart Valve		
Chest Pains			Hepatitis/Jaundice			Mitral Valve Prolapse		
Stroke			AIDS or HIV			Endocarditis		
Angina			Blood Disease			Smoke/Chewing Tobacco		
Heart Attack			Excessive Bleeding			Emphysema		
Pacemaker			Anemia			Respiratory Problems		
Heart Murmur			Stomach/Ulcers			Asthma		
Rheumatic Fever			Sinus Problems			Tuberculosis		
Epilepsy/Seizures			Cancer			Arthritis		
Fainting/Dizziness			Radiation			Osteoporosis		
Diabetes			Chemo			Taken Bone Density Meds		
Swollen Ankles			Dry mouth			Pregnant		
Frequently Tired			Organ transplant			Nursing		
Thyroid Problem			Kidney Disease			Other		

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date_____

Signature of patient (or parent/guardian if minor)

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Radiograph and Records Release Request

To: _____

_____

I respectfully request that a copy of my records and/or x-rays be sent to my Dentist.

Please email to: frontoffice@sevenspringsdental.com

Or mail to:

Seven Springs Dental Excellence

2220 Seven Springs Blvd.

New Port Richey, FL 34655

(727) 375-7370

Fax (727) 375-7468

Thank you for your assistance with this request.

Patient name: _____

Phone Number: _____

Address: _____

_____

Signature of patient (or parent/guardian) :

_____

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Patient Consent Form

I UNDERSTAND THAT, UNDER THE Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME:_____

SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____

DATE:_____

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Cancellation and Missed Appointment Policy

A therapeutic relationship is built on mutual trust and respect. As such, every effort will be made to be on time for your appointment, and ask that you give the same courtesy of a call when you are unable to keep your appointment. Please read, sign and date the cancellation & missed appointment policy below.

1) If you are unable to keep a scheduled appointment, you must contact the office via telephone at least 24 hours prior to your appointment.

2) If you fail to notify the office of your cancellation within the time stated above and miss your scheduled appointment, a **$50 fee** for the missed or cancelled appointment will be charged.

3) At the time of cancellation, another appointment will be offered to you that may work better for your schedule.

4) Four (4) missed appointments can result in an administrative discharge from the practice.

5) To cancel or reschedule appointments, please call (727) 375-7370.

_____

_____

Signature & Date