SMILES of PUNTA GORDA
JEREMY MARTIN DMD

PATIENT REGISTRATION

Please complete the following confidential information

PATIENT INFORMATION

Date			
Last Name	First		MI
Preferred name			
Address			
City	St	Zip	
Hm. Phone	Cell Phone		
Email			
Birthdate	Age	Male	Female
Married	Single	Divorced	Widowed
Social Security			

Guardian Information (if applicable)

Last Name	First Name		MI
Address			
City	St	Zip	
Hm. Phone			
Birthdate	Age	Male	Female

Dental Insurance

Primary Carrier	
Insurance Company	
Group No.	
Employer Name	
Insured Name	
Date of Birth	Relationship to pt.
Insured I.D. No.	
Social Security No.	
Secondary Carrier	
Insurance Company	
Group No.	
Employer Name	
Date of Birth	Relationship to pt.
Insured I.D. No.	
Insured SSN	

EMERGENCY CONTACT

Name _____

Phone Number _____

Relationship _____

Is another member of your family or relative a patient of our practice? _____

How did you hear about Smiles of Punta Gorda? _____

Consent for Treatment

1. I hereby authorize doctor and his team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient name) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetics agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature _____ Date _____

Parent/Responsible Party Signature _____

Relationship to patient _____

Patient Name	Medical Alert

Medical History

1. **Have you ever been under the care of a medical doctor during the past two years?** **Yes No**
   If yes, please specify _____
   Physician's Name _____ **Phone** _____

2. **Have you ever taken medicine for osteoporosis?** **Yes No**
3. **Are you taking any medications, drugs or pills now, including regular dosage of aspirin?** **Yes No**
   If yes, please list medication name and dosage: _____
   _____
   _____
4. **Are you aware of having an allergic (or adverse) reaction to any medication or substance?** **Yes No**
   If yes, please list: _____
5. **Indicate which of the following diagnosis you have had in the past or have at present time. Circle Yes or No to each.**

Heart (Surgery, Disease, Attack)	**Yes**	**No**	**Asthma**	**Yes**	**No**
Heart Murmur	**Yes**	**No**	**Latex Sensitivity**	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	**Radiation Therapy**	**Yes**	**No**
Mitral Valve Prolapse	**Yes**	**No**	**Chemotherapy**	**Yes**	**No**
Artificial Heart Valve	**Yes**	**No**	**Sinus Trouble**	**Yes**	**No**
Heart Pacemaker	**Yes**	**No**	**Hepatitis A (infectious) B (serum) C**	**Yes**	**No**
Rheumatic Fever	**Yes**	**No**	**Cold Sores/Fever Blister**	**Yes**	**No**
Arthritis/Rheumatism	**Yes**	**No**	**A.I.D.S.**	**Yes**	**No**
Stroke	**Yes**	**No**	**H.I.V. Positive**	**Yes**	**No**
Artificial Joints (hip, knee, etc.)	**Yes**	**No**	**Bruise Easily**	**Yes**	**No**
Kidney Trouble	**Yes**	**No**	**Liver Disease**	**Yes**	**No**
Diabetes Type 1 Type 2	**Yes**	**No**	**Epilepsy or Seizures**	**Yes**	**No**
Thyroid Problems	**Yes**	**No**	**Nervous/Anxious**	**Yes**	**No**
Emphysema	**Yes**	**No**	**Neurological Disorders**	**Yes**	**No**
Chronic Cough	**Yes**	**No**	**Smoke or Chew Tobacco**	**Yes**	**No**
Tuberculosis	**Yes**	**No**			

6. **Do you have or have had a Diagnosis, Condition or Problem not listed?** **Yes No**
   If yes, please list: _____
7. **Women are you Pregnant? Yes, _____ months No**

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ **Date** _____

History Review

Dentist Signature _____

Dental History

Patient Name	Medical Alert

What are you expectations for your visit today? _____

_____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-Rays** _____

On average, how often did you visit you dentist/hygienist? _____

How often do you brush your teeth? _____ **How often do you floss?** _____

What other dental aids do you use? (interplak, toothpick, etc.) _____

Are you satisfied with your teeth's appearance?	**Yes**	**No**
Would you like to keep your teeth all of your life?	**Yes**	**No**
Do you feel nervous about having dental treatment?	**Yes**	**No**

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience	**Yes**	**No**

If yes, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know?

_____

Do you have any dental concerns at the time?	**Yes**	**No**

If yes, please describe _____

Have you ever had periodontal treatment?	**Yes**	**No**
Have you noticed any mouth odors or bad taste?	**Yes**	**No**
Do your gums bleed or hurt?	**Yes**	**No**
Have your parents experienced gum disease or tooth loss?	**Yes**	**No**

Do You:

Clench you teeth while awake or asleep?	**Yes**	**No**
Have you ever had a bite plate or mouth guard?	**Yes**	**No**
Do you Mouth Breathe while awake or sleep?	**Yes**	**No**
Do you have tired jaws, especially in the morning?	**Yes**	**No**
Do you have clicking or popping of the jaw?	**Yes**	**No**
Do you have pain (joint, ear, side of face)?	**Yes**	**No**

Notice of Privacy Practices

Written Acknowledgement Form

Under Florida State Law

Prudent risk management requires signature to consent to Smiles of Punta Gorda to disclose protected health information for use to carry out treatment, payment or health care operations.

I, _____have been offered a copy of Smiles of Punta Gorda's Notice of Privacy Practices, and give acknowledgement, consent, and authorization to use or disclose protected health information to carry out treatment, payment, or health care operations.

_____ _____

Signature of Patient Date

Smiles of Punta Gorda Notice of Privacy Practices

This notice describes how your health information may be used, disclosed, and how you can access this information. Please review the following carefully.
Smiles of Punta Gorda is required by law to keep your health information secure and confidential. By law, we need to give you this notice and to follow the terms of this notice.

- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.
- We may use or disclose your health information for our normal operations. For example, one of our team will enter your treatment information into our computer system.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information, when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose some or all of your health information without your prior written authorization.
- You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.
- You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.
- You have the right to request an amendment or change to your health information in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include a statement in your file. If we agree to an amendment or change, we will not remove not alter earlier documents, but will add new information.
- You have the right to receive a report of who we disclose your information to.
- If our privacy/security measures and systems are breached in any way, we will notify you.
- You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W. Room 509F, Washington DC 20201) online (www.hhs.gov) or by email (OCRComplaint@hhs.gov) You will not be retaliated against for filing a complaint. Please contact our Privacy Officer, Lynda Holden at (941) 575-2626 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.