Patient Information

Date: _____

Daytime Phone (___) _____ Cell Phone (___)_____

Full Name _____ Birthdate _____

Address _____ SS # _____

City _____ State_____ Zip _____

Northern Address _____ In Florida how many months?____

Sex: ☐Male ☐ Female ☐ Married ☐ Widowed ☐ Single ☐ Child

Patient Employer _____Employer Phone: (___)_____

Whom may we thank for referring you? _____

Are any of your family members already patient's here? ☐Yes ☐No

If yes, name of family member _____

Payment Method? ☐Cash ☐Check ☐ Credit Card ☐ Care Credit

In case of an emergency who should be notified?_____

Emergency Contact Person's Phone Number (___) _____

Primary Insurance

Person Responsible for Account Last Name _____ First Name _____ M.I._____

Relation to Patient _____ DOB _____SS# _____

Address (if different from patient's) _____ Phone (___) _____

City _____ State_____ Zip _____

Person Responsible Employed By _____ Occupation_____

Business Address _____Business Phone (___) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber #_____

Names of other dependents covered under this plan _____

_____

Additional/ Secondary Insurance

Is patient covered by additional dental insurance? ☐Yes ☐No

Medical History

Patient's Name _____

Physician's Name _____

Date of Last Visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, give approximate dates _____

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

Check if you have or have had any of these conditions :

☐ Anemia	☐ Cortisone Treatment	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Thyroid Problems
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Tobacco Habit
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Congenital Cardiac Malformations
☐ Osteoporosis			

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

Doctor's Signature_____ Date _____

Smile Evaluation

By filling out this Smile Evaluation, our team will be able to help you obtain the smile you have always wanted. Please feel free to discuss with our staff any questions or areas of concern. This allows our practice to maintain our focus and time spent on the delivery of the best quality of dental care.

Name: _____ Date: _____

Are you pleased with the appearance of you teeth when you smile?		☐ Yes	☐ No
Are you pleased with the color of your teeth?		☐ Yes	☐ No
Are you pleased with the shape of your teeth?		☐ Yes	☐ No
Are you pleased with the appearance of your gums when you smile?		☐ Yes	☐ No
Are your gums puffy, red or swollen looking? Do they bleed easily?		☐ Yes	☐ No
Do your old fillings still please you?		☐ Yes	☐ No
Are your teeth:	Chipped?	☐ Yes	☐ No
	Protruding?	☐ Yes	☐ No
	Crowded?	☐ Yes	☐ No

If you would like to change anything about the appearance of you smile what would that be?

_____

_____

_____

_____

Check if you have problems with any of the following:

☐ Bad Breath	☐ Sores or growths in mouth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Grinding teeth	☐ Sensitivity to cold

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

A copy of our Notice of Privacy Practices is available upon request.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices, and either, have read or declined to read them.

This form will remain in my patient chart.

_____ _____

Print Name Date

_____

Signature

NORTH PORT DENTAL

Agreement to Receive Electronic Communication

Patient Name:_____ Date of Birth:_____

Please read the following statement and initial accordingly:

That the dental practice may communicate with me electronically at the email address and /or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

I_____ DO AGREE

I_____ DO NOT AGREE

Please complete the following section <u>ONLY</u> if you've agreed to the above terms.

Initial below to indicate your preferred method of communication

_____ Phone call

_____ Text Messaging

_____ Email

I would like to receive:

_____ Appointment Reminders/Recall Visits

_____ Information regarding insurance/billing

_____ Requests for Patient Satisfaction online reviews

Please be advised you can withdraw your consent to receive electronic communications at any time by calling us at (941) 426-8289 or by emailing northportdental@gmail.com

Patient Signature:_____ Date:_____

14884 TAMIAMI TRAIL • NORTH PORT COMMONS
NORTH PORT, FL 34287
PHONE: (941) 426-8289• FAX: (941)426-8726

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.