Date:______________ **Daytime** Phone (____)_______________
Cell Phone (____)_______________

Patient Information

Full Name________________________________ **Birthdate** _________________________

Address_________________________________ SS #_____________________________

City__________________________________ State______________ Zip______________

Northern Address______________________ City________________ State_________ Zip_________

Email ____

How would you prefer to be contacted? ☐ Call ☐ Text ☐ Email

Sex ☐ Male ☐ Female **Status** ☐ Married ☐ Widowed ☐Single ☐ Child

Patient Employer __________________________ **Employer Phone** (_____)_______________

Whom may we thank for referring you? ____

Are any of your family member already patient's here? Yes _________ No __________
If yes, name of family member ____

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_______________________________

Medical Dr.'s Name____________________________ **Date of Last Visit There** ________________

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 date(s)_________________

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 *Do you take an oral or injectable medication for this?
IF YES, how long have you been taking it? _______________

<u>ALLERGIES</u>

____

____

<u>MEDICATIONS</u>
Only list meds you're currently taking:

____

____

Doctor's Signature_________________________ Date __________________________________

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:_______

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