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? _____

ALLERGIES

_____

_____

MEDICATIONS
Only list meds you're currently taking:

_____

_____

Doctor's Signature_____ Date _____

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

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

No Show/Reschedule Policy

As all our existing patients know, North Port Dental is a very busy office. If you have tried to reschedule an appointment (especially on short notice) you are likely aware how hard it can be to get back into our schedule. Due to frequent same day cancellations and "no call, no show" missed appointments we are implementing something that is a long time coming.

Effective January 1st, 2022: Any missed appointments (no call, no show) or same day cancellations (less than 24 hours' notice given) will be charged a $50 fee (non-negotiable or refundable, no exceptions).

We kindly ask for *only* 24 hours' notice to cancel or reschedule. If that is given there is no charge to move/change an existing appointment. We value your time, please value ours.

_____ _____

Printed Name Patient DOB

_____ _____

Signature Date

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