PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ **Home Phone:** _____ **Alt. Phone** _____

Patient _____

LAST NAME FIRST NAME MIDDLE INITIAL PREFERRED NAME

Street Address _____ **City** _____ **State** _____ **Zip** _____

Sex ☐ **Male** ☐ **Female** **Age**_____ **DOB** _____ ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Employed by _____ **Occupation** _____

Spouse/Parent Name _____ **Spouse Parent Birthdate** _____

Spouse/Parent Employed by _____ **Occupation** _____

Business Address _____ **Business Phone** _____

Who is responsible for this account? _____ **Relationship to patient** _____

Social Security # _____ **Spouse/Parent Social Security #** _____

Name of Dental Insurance Company _____ **Group Number** _____

In Case of Emergency, who should be notified? _____ **Phone** _____

Whom many we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ **Date of last Physical** _____

Have you ever had any of the following? (Check all boxes that apply):

☐ Heart Murmur	☐ Epilepsy	☐ Osteoporosis
☐ High Blood Pressure	☐ Headaches	☐ Cancer
☐ Low Blood Pressure	☐ Hepatitis, Jaundice or Liver Disease	☐ Swollen neck glands
☐ Circulatory Problems	☐ Excess alcohol consumption	☐ Rheumatic Fever
☐ Nervous Problems	☐ Psychiatric Care	☐ Sinus Problems
☐ Radiation Treatment	☐ Mitral Valve Prolapse	☐ AIDS/HIV
☐ Artificial Heart Valves/Joints	☐ Allergies to Anesthetics	☐ Thyroid Disease
☐ Recent Weight Loss	☐ Allergies to medicines or drugs	☐ Stroke
☐ Asthma	☐ General Allergies	☐ Ulcer
☐ Diabetes	☐ Blood Disease	☐ Venereal Disease
☐ Respiratory Disease	☐ Arthritis	☐ Chemical Dependency
☐ Hemophilia	☐ Currently taking Bisphosphonates	

Do you have allergies or have you ever had an adverse reaction to any medication? _____ **If so, what** _____

_____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking medication at this time? _____ **If so, what?** _____

Are you under the care of a physician? _____ **For what conditions?** _____

If patient is a child, what is his or her weight? _____ **(Women) Do you suspect that you are pregnant?** _____ **Are you nursing?** _____

Is there anything else we should know about your medical history? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ **Patient Signature:** _____

Date: _____ **Dentist Signature:** _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____

Name of Insurance Company (ies)

And assign directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date: _____ Signature: _____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: _____ Signature: _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment for all procedures, unless other arrangements have been made in writing. All prosthetic services are considered completed after a decisive appointment has been rendered. The decisive appointment for full/partial dentures, crown & bridge, and other prosthetic services is the date the final impression was performed. The decisive appointment for root canal therapy is the date the canal is opened. I agree to give my insurance carrier permission to pay in full for all procedures which have reached decisive appointment. I agree that parent/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date: _____ Signature: _____

MEDICAL HISTORY UPDATE (*to be completed on subsequent visits*)

Have there been any changes in your health since your last dental appointment? ☐ No ☐ Yes, for what conditions? _____

_____

Are you taking any new medications? _____ If so, what? _____

Date: _____ Patient Signature: _____

Date: _____ Dentist Signature: _____

Have there been any changes in your health since your last dental appointment? ☐ No ☐ Yes, for what conditions? _____

_____

Are you taking any new medications? _____ If so, what? _____

Date: _____ Patient Signature: _____

Date: _____ Dentist Signature: _____

Have there been any changes in your health since your last dental appointment? ☐ No ☐ Yes, for what conditions? _____

_____

Are you taking any new medications? _____ If so, what? _____

Date: _____ Patient Signature: _____

Date: _____ Dentist Signature: _____

DENTAL HISTORY

1. Reason for today's visit? _____

2. Name of your previous Dentist _____ Phone _____

3. Address of your previous Dentist _____

4. Date of your last dental visit _____ and last x-rays _____

5. Are you completely satisfied with your smile? Explain _____

_____

6. How many times a day do you brush your teeth? _____

7. Do you use dental floss regularly? _____ ☐ Yes ☐ No

8. Do your gums bleed or hurt when you brush them? _____ ☐ Yes ☐ No

9. Do you feel you have bad breath? _____ ☐ Yes ☐ No

10. Do any of your teeth feel loose? _____ ☐ Yes ☐ No

11. Do you have a tooth ache? _____ ☐ Yes ☐ No

12. Are your teeth sensitive to heat, cold, sweets? _____ ☐ Yes ☐ No

If so, explain _____

13. Do you clench, or grind your teeth during the day or at night? _____ ☐ Yes ☐ No

14. Does your jaw click or pop when chewing? _____ ☐ Yes ☐ No

15. Do you have any jaw pain? _____ ☐ Yes ☐ No

16. Do you have frequent headaches? _____ ☐ Yes ☐ No

17. Does food collect between your teeth? _____ ☐ Yes ☐ No

18. Do you snore while sleeping? _____ ☐ Yes ☐ No

FOR PARENTS

19. Does your child suck his or her thumb? _____ ☐ Yes ☐ No

20. Does your child go to sleep with a bottle in his mouth; do you use the bottle as a pacifier? ☐ Yes ☐ No

I certify that the above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patients Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

HEALTHY SMILES DENTAL GROUP

MIGUEL R. GRILLO, D.D.S., P.A.
(561) 784-4670 • Fax: (561) 791-1390
9136 Forest Hill Blvd.
Wellington, FL 33411

BROKEN APPOINTMENT AGREEMENT

I, _____ am aware that there is a broken appointment fee for any appointments that I either **miss, change or cancel without a 24 hour notice**. I understand that this time has been reserved for my personal dental needs.

The fees are as follows:

1. General dentist appointment: $30 per half hour/$60 per hour
2. Hygienist: $30 per half hour/$60 per hour
3. Orthodontic treatment: $30 per appointment
4. Osseous Surgery: $200 per visit
5. Scaling & Root Planning: $ 75 per visit
6. Periodontal maintenance: $50

Patient Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT)

I, _____ have received and read a copy of this office's Notice of Privacy Practice.

Patient Signature _____ Date _____

If you are a legal representative of the patient, please print the patient's name and describe your authority:

Office Use Only

As a privacy officer, I attempted to obtain the patient's (or representatives) signature on this acknowledgement but did not because:

_____ It was emergency treatment

_____ I could not communicate with the patient

_____ The patient refused to sign

_____ The patient was unable to sign because: _____

_____ Other: _____

Signature of Privacy officer _____

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TREATMENT BREAKDOWN

Patient Name: _____ Date: _____

The following treatment has been diagnosed:

_____ $_____	_____ $_____
_____ $_____	_____ $_____
_____ $_____	_____ $_____
_____ $_____	_____ $_____
_____ $_____	_____ $_____
_____ $_____	_____ $_____
_____ $_____	_____ $_____
_____ $_____	_____ $_____
_____ $_____	_____ $_____
_____ $_____	_____ $_____
_____ $_____	_____ $_____
_____ $_____	_____ $_____

Total fee: $_____

Patient (or guardian, if minor) signature: _____

Approved by: _____ Date: _____

Note: These fees are the responsibility of the patient or guardian.