PATIENT REGISTRATION AND MEDICAL HISTORY

Home Phone: _____ **Alt. Phone** _____ **Email** _____

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

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

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 SMILE DENTAL GROUP, P.A.

9136 Forest Hill Blvd
Wellington, FL. 33414
(561) 784- 4670

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have received a copy of this office Notice Privacy Practice.

Patients signature _____ Date _____

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

Office Use Only As privacy officer, I attempted to obtain the patients (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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Broken Appointment Agreement

I, _____ am aware that there is a broken appointment fee for any appointments that I either **miss, changed or cancelled 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. Periomaintenance:$50

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

SEXTANT

UPPER			
LOWER			

PERIODONTAL POCKET PROBING EXAMINATION INFORMED CONSENT

In order to perform a comprehensive intra-oral examination, it is necessary to probe each natural tooth. Radiographs (x-rays) alone can only provide a partial evaluation of the periodontal condition: a complete evaluation of periodontal condition can only be performed by the use of a periodontal probe. This procedure enables the doctor to measure the depth of periodontal pockets in up to six locations per tooth thus establishing a baseline index by which any future probing measurements can be compares. Early diagnosis of periodontal disease can, in most cases, assist in proper treatment protocols and, with proper home care and periodic professional periodontal care in periodontal probing examination.

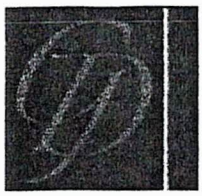
In order to complete this examination, a needle-like metal or plastic probe demarcated in 1 millimeter increments is inserted between the tooth and gum tissue in six locations around each natural tooth (3 locations on the cheek side and 3 locations on the tongue/plate side). You may experience some sensitivity and/or bleeding during or after this examination. No local anesthetic is utilized in performing this examination.

PLEASE CHECK (_) *ONLY ONE* BOX.

- ☐ I would like to have a complete periodontal probing examination.
- ☐ I would like to have my regular dental examination and will call to reschedule the periodontal probing examination.
- ☐ I would like to have my regular dental examination and decline to have the periodontal probing examination. I understand that I am releasing Dr. Grillo from any liability from not having a periodontal probing examination.

I have read the above passage and know and understand the contents thereof as to the necessity of the periodontal probing examination in determining, detecting and diagnosing disorders of the periodontal support structures. I understand by declining periodontal probing I hereby remise, release, acquit, satisfy and discharge the said release (Dr. Grillo and associates) of and from all action or actions, cause and causes of action, suits, debts, damages, judgments, claims and demands whatsoever, which said releaser ever had, now has, hereafter can, shall or may have against said release. I sign this release voluntarily with knowledge of its significance intending to be legally bound thereby.

SIGNATURE: _____ DATE: _____



HEALTHY SMILES DENTAL GROUP

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Wellington, FL 33411

CONSENT OF TREATMENT

1. **EXAMINATION AND X-RAYS**: I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.
2. **CHANGES IN TREATMENT PLAN**: I understand that, during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination- the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions to the treatment plan as necessary.
3. **DRUGS, MEDICATION, AND SEDATION**: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand this and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of any anesthetic medication or drugs that may be given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.
4. **FILLINGS**: I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.
5. **CROWNS, BRIDGES, VENEERS AND BONDING**: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.
6. **DENTURES- COMPLETE OR PARTIAL**: I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not in the initial denture fee.
7. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save a tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
8. **PERIODONTAL TREATMENT:** I understand that serious periodontal conditions causing gum inflammation and/or bone loss can lead to the loss of my teeth. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.
9. **REMOVAL OF TEETH (EXTRACTION):** I understand that if a tooth is not savable by e.g. root canal therapy, crowns, periodontal surgery, etc., it may be recommended that the tooth be extracted. I understand removing teeth does not always remove all infection if present and it may be spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (parathesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
10. **TEMPORAMANDIBULAR JOINT DYSFUNCTIONS (TMJ):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

CONSENT: I have read and understood the above information. Further, I understand that dentistry is not an exact science: therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other that the treating Dentist is responsible for my dental treatment.

SIGNATURE: _____ ***DATE:*** _____