Ormond Family Dental
1200 W. Granada Blvd
Suite 2
Ormond Beach, FL 32174
Ph # : 386-275-1792
Fax # : 386-265-0576

Patient Personal Information

Title ____ Nickname ____		Birth Date ____	Age ____
Last, First ____ ____ ____		Marital Status ____	Sex ____
Address ____		Home # ____	Work # ____
____		Cell # ____	Drive Lic ____
City, State, Zip ____		Student ____	SSN ____
Email ____		School Name ____	
		Referral Type ____	

Person responsible/guarantor for paying bills

Title ____ Nickname ____	Birth Date ____	Age ____
Last, First , ____ ____ ____	Marital Status ____	Sex ____
Address ____	Home # ____	Work # ____
____	Cell # ____	Drive Lic ____
City, State, Zip ____	SSN ____	
Email ____		

Do you have Primary Dental Insurance? __ Yes __ No	**Do you have Secondary Dental Insurance?** __ Yes __ No
Group No/Name ____	Group No/Name ____
Insurance Name ____	Insurance Name ____
Phone # ____	Phone # ____
Employer Name ____	Employer Name ____
Subscriber Last, First ____	Subscriber Last, First ____
Subscriber Address ____	Subscriber Address ____
City, State, Zip ____ ____	City, State, Zip ____
Relationship to Patient ____ Birth Date ____	Relationship to Patient ____ Birth Date ____
Subscriber ID ____	Subscriber ID ____

Patient Medical Information

Allergic To

- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Barbiturates / Sleeping Pills
- ☐ Codeine / Other Narcotics
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex Rubber
- ☐ Local Anesthetics
- ☐ Metals
- ☐ No Epinephrine
- ☐ Penicillin
- ☐ Prior Hepatitis
- ☐ Sulfa Drugs

Check, if applicable

- ☐ AIDS/HIV Infection
- ☐ Alcohol/Drug Abuse
- ☐ Anemia / Leukemia
- ☐ Ankles Swell
- ☐ Anorexia / Bulimia
- ☐ Arthritis
- ☐ Asthma / Hay Fever
- ☐ Blood Clotting Problems
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer / Tumor or Growth
- ☐ Cardiac Pacemaker
- ☐ Chest Pain Upon Exertion
- ☐ Color Blindness
- ☐ Contact Lenses
- ☐ Damaged Heart Valve
- ☐ Diabetes
- ☐ Emphysema
- ☐ Environmental Allergies
- ☐ Epilepsy
- ☐ Fainting Spells / Seizures
- ☐ Fever Blisters / Herpes
- ☐ Frequent Headaches
- ☐ Frequently Dry Mouth / Sjogren
- ☐ Gall Bladder Trouble
- ☐ Heart Attack / Stroke
- ☐ Heart Disease / Angina
- ☐ Heart Murmur
- ☐ Hepatitis / Jaundice
- ☐ High Blood Pressure
- ☐ Hives / Skin Rash
- ☐ Joint Replacement
- ☐ Kidney / Bladder Trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Mitral Valve Prolapse
- ☐ Persistent Diarrhea
- ☐ Premedicate
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Stomach Ulcers
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Unusual Weight Loss
- ☐ Urinate Frequently

Dental Questionnaire

Dental Questionnaire

Purpose of today's visit? ______________________

Name of previous Dentist? ______________________

Last visit? ______________________

What treatment did you receive? ______________________

Date of your last cleaning ______________________

Do you regularly use dental floss ? ______________________

How often do you brush? ______________________

Date of your last full series x-rays ______________________

Do your gums bleed while brushing or flossing ? ______________________

Are your teeth sensitive to hot, cold or sweets ? ______________________

Do you have problems with teeth/fillings breaking ? ______________________

Do you have an unpleasant taste or odor in your teeth/mouth ? ______________________

Are you having any specific problems with your teeth, gums, or mouth at this time ? ______________________

Any persistent sores or ulcerations anywhere in your mouth? ______________________

Do you clench or grind your teeth ? ______________________

Do you want to learn to control your dental disease and retain your teeth ? ______________________

Do you chew/smoke tobacco in any form ? ______________________

Are you happy with the color of your teeth and your smile ? ______________________

Have you ever had tooth whitening? What type? ______________________

Are you interested in any cosmetic dental treatment? ______________________

Are you interested in replacing any missing teeth? ______________________

How would you like to replace any missing teeth? Dentures, fixed bridges, or permanent implants? ______________________

Are you interested in an interest free payment plan? ______________________

Do you have any questions for the Dentist? ______________________

Medical Questionnaire

1. Are you in good health? ______________________

2. Has there been any change in your general health in the past year? ______________________

3. Date of last physical exam? ______________________

4. Are you now under a physician's care for a particular problem? ______________________

5. Have you ever had any serious illnesses, operations or hospitalizations? If so describe... ______________________

6. Height and Weight? ______________________

DO YOU HAVE OR HAVE YOU EVER HAD:

A. Have you ever had or been tested positive for: ☐

HIV/AIDS, ARC, HEPATITIS B or C? __________

i) if yes, when? __________

ii) If yes, are you willing to provide current HIV, HBV and HCV blood test status? __________

iii) Are you willing to be re-tested? __________

B. Rheumatic Fever or Rheumatic Heart Disease? __________

C. Congenital Heart Disease? __________

D. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, etc.) __________

E. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, TB, Severe Coughing, etc.) __________

F. Seizures, Convulsions, Epilepsy, Fainting or Dizziness __________

G. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? __________

H. Liver Disease (Jaundice, Hepatitis)? __________

I. Kidney Disease? __________

J. Diabetes? __________

K. Thyroid Disease (Goiter)? __________

L. Arthritis? __________

M. Stomach Ulcers or Colitis? __________

N. Glaucoma? __________

O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? __________

P. Radiation (X-Ray) treatment for cancer? __________

Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? __________

R. Sinus or Nasal problems? __________

S. Any disease, drug or transplant operation that has depressed your immune system? __________

7. ARE YOU USING ANY OF THE FOLLOWING:

A. Antibiotics? __________

B. Anticoagulants (Blood Thinners)? __________

C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? __________

D. High Blood Pressure medications? __________

E. Steroids (Cortisone, etc.)? __________

F. Tranquilizers __________

G. Insulin or Oral Anti-Diabetic drugs? __________

H. Digitalis, Inderal, Nitrogylcerin or other heart drug? __________

I. Are you taking or have you ever taken Bisphosphonates(Fosamax, Actonel or Boniva) __________

J. Please list any and all medications taken, including prescription medications, over-the-counter, __________

8. Do you smoke or chew Tobacco? __________

How much per day?	____________
9. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affec	____________
10. Have you had any serious problems associated with any previous dental treatment?	____________
11. Have you or an immediate family member had any problem associated with IV anesthesia?	____________
12. Do you have any other disease, condition or problem not listed that the doctor should know about	____________
13. Do you wish to talk to the doctor privately about anything?	____________
14. FOR WOMEN ONLY	
A. Are you Pregnant, or is there any chance you might be Pregnant?	____________
B. Are you nursing?	____________
C. Are you using oral contraceptives?	____________
If so- and you require any prescription medication from your dentist, consult with your M.D.	☐

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature ____________ **Date** ____________

Ormond
Family dental

ASSURANCE OF PRIVACY FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and expense. We want you to know that all of our employees, managers and Doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing our services to our patients. It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and disclosure of PHI. As part of this plan, we implemented a compliance program that we believe will help us prevent any inappropriate use of PHI. We realize there is always room for improvement! It is our policy to listen to employees and our patients. If you feel your privacy has been compromised in any way, please ask to speak with our compliance officer or express your concerns to your Dentist. Please read the following "Notice of Privacy" after reading, please sign and return this form to the receptionist. If you have any questions, please don't hesitate to ask. Thank you.

NOTICE OF PRIVACY

The Department of Heath Human Services had established a "Privacy Rule "to help insure that personal information (PHI) is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing patient health information that is needed to carry out proper treatment, payment, or health care operations.

As a patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to always protect your privacy. When it is appropriate and necessary, we provide the minimum amount of necessary information to only those who we feel are in need of your health care information. We strive to provide the best health care that is in your best interest. We also would like you to know that we support your full access to your medical records. If you want to request restrictions pertaining to parties you do not want PHI released to, please tell our compliance officer and it will be documented in your chart. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies of this form, please ask to speak with our compliance officer. You have the right to review our entire privacy policy manual upon request. Please sign this form acknowledging that you have read and agree this patient notice of privacy.

Patient Name (please print)____

Signature____ Date______________

If Minor, Signature of Parent or
Guardian____ Date______________

Ormond Family Dental

Office Policies

Thank you for choosing us as your dental health provider. We are devoted to *restoring* and *enhancing* the natural beauty of your smile using conservative, state-of-the-art procedures that will result in a beautiful, healthy, and long lasting smile! Please take a moment to review the following office policies. If you have any questions, please feel free to ask any staff member for more information. Please initial each office policy after reviewing.

Appointments

_____In order to provide you with the attention and level of care you deserve, we reserve a significant amount of time and reserve a specific room for your visit. We also understand that your time is valuable and, because of that, we make every effort to see you at the appointed time. On the other hand, your promptness and consideration in not changing your reserved time is very much appreciated. In the event you must change an appointment, a minimum of 24-hr notice is required. **Please note that a fee of $41 will be applied for appointments missed without notice and for canceling appointments with less than 24 hour notice.**

_____Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.

Insurance/Financial

_____As a courtesy to our patients, we accept assignment of benefits from most insurance companies. However, we do **require you to pay your deductible and/or "estimated patient portion" at the time of service.**

_____Your insurance company may pay alternate benefits for certain procedures such as bridge work. **Cosmetic Restorations; for example, white fillings, are sometimes paid at a lower rate than our estimate. You will be billed for the remaining balance.**

_____**It is your responsibility to understand your dental insurance benefits and to inform the office of any changes to your insurance before treatment is rendered.**

_____Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Any and all fees quoted for dental treatment are based on the current information provided to us by your insurance carrier. **Any difference in payments made by or procedures denied by your insurance carrier are your responsibility.**

_____The adult accompanying a minor is responsible for full payment.

Thank you for reviewing and understanding our guidelines. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above policies.

______________________	______________________	______________
Patient's Name-Please Print	Patient's (or Legal Guardian's) Signature	Date
______________________	______________________	______________
Witness's Name-Please Print	Witness's Signature	Date