TOMOKA PERIODONTICS
& IMPLANT DENTISTRY

Welcome To Our Practice

Thank you for trusting us with your dental care.
We promise to do our best to provide you with the finest care available.
If you have any questions, please do not hesitate to contact us.

Date _____

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Name _____ Birth Date _____

Sex ❑ M ❑ F Address _____ City _____ State _____ Zip _____

❑ Minor ❑ Married ❑ Widowed ❑ Single ❑ Partnered ❑ Divorced Soc. Sec. # _____

Home Phone _____ Cell Phone _____ E-mail _____

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Dentist _____ Medical Doctor _____

Whom may we thank for referring you? *(e.g., General Dentist)* _____

Contact in case of emergency _____ Phone _____ Relation to Patient _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other
(If self, skip to next section)

Name _____ S.S.# _____ Birth Date _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Currently a patient in our office? ❑ Yes ❑ No E-mail _____ Cell Phone _____

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Insurance Company Name _____

Insurance Company Address _____ City _____ State _____ Zip _____

Insurance Company Phone _____

Group # _____ **ID #** _____

Subscriber _____ Relation to Patient _____

Sex: ❑ M ❑ F Birth Date _____ S.S # _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell Phone _____ Email _____

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MEDICAL HISTORY

Are you a nervous or tense person? ❑ Yes ❑ No

Are you under the care of a physician? ❑ Yes ❑ No

Rate your dental fear: ❑ Mild ❑ Moderate ❑ Severe

Last Physical Exam: Date_____

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N	
❑	❑	Abnormal Bleeding	❑	❑	Immune Suppressive Disease
❑	❑	AIDS/HIV (Circle One)	❑	❑	Joint Replacement/(specify year & joint)_____
❑	❑	Anemia	❑	❑	Kidney Trouble
❑	❑	Arteriosclerosis	❑	❑	Liver Disease / Jaundice (Circle One)
❑	❑	Arthritis / Joint Disease (Circle One)	❑	❑	Low Blood Sugar
❑	❑	Asthma	❑	❑	Mental Health Problems
❑	❑	Chemotherapy	❑	❑	Mitral Valve Prolapse
❑	❑	Cold Sores / Fever Blisters	❑	❑	Osteoporosis / Osteopenia (Circle One)
❑	❑	Contagious Diseases_____	❑	❑	Pain in Jaw Joints
❑	❑	Convulsions / Epilepsy (Circle One)	❑	❑	Prostate Trouble (Men)
❑	❑	Delay in Healing	❑	❑	Radiation
❑	❑	Diabetes	❑	❑	Sexually Transmitted Diseases
❑	❑	Eye Disease / Glaucoma (Circle One)	❑	❑	Smoke or Tobacco in Any Form
❑	❑	Fainting Spells	❑	❑	Stomach Ulcers
❑	❑	Frequent Headaches	❑	❑	Stroke
❑	❑	Hay Fever/Sinus Problems (Circle One)	❑	❑	Tendency to Faint
❑	❑	Heart Attack(s)	❑	❑	Thirsty / Dry Mouth
❑	❑	Heart Condition	❑	❑	Thyroid Problems
❑	❑	Heart Murmur	❑	❑	Tuberculosis
❑	❑	Hepatitis A B C (circle one)	❑	❑	Tumor or Growth
❑	❑	High / Low Blood Pressure (circle one)	**For Women Only:**		
❑	❑	History of Drug Abuse	Is there a possibility of pregnancy? ❑ Yes ❑ No		

MEDICATION and ALLERGIES

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N	
❑	❑	Antibiotics (specify)_____	❑	❑	Codeine or Other Narcotics	❑	❑	Local Anesthetic
❑	❑	Amoxicillin	❑	❑	Food (specify)_____	❑	❑	Penicillin
❑	❑	Aspirin	❑	❑	Latex	❑	❑	Sulfa Drug

Other: _____

Are you now taking or have you taken:

Y	N		Y	N		Y	N	
❑	❑	Antianxiety Medications	❑	❑	Insulin	❑	❑	Pain Medications
❑	❑	Antidepressants	❑	❑	Muscle Relaxers	❑	❑	Stimulants
❑	❑	Blood Thiners						
❑	❑	Bone Density Medication or Bisphosphonates *(Actonel,Aredia,Boniva,Fosomax,Prolia,Reclast, Zometa)*						

Have you been advised to pre-medicate for medical reasons *(e.g., antibiotics)* prior to dental treatment? ❑ Yes ❑ No

List the medication(s) you are taking (including natural, herbal, or homeopathic products) that are not listed above:

_____

_____

_____

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* _____ **Reviewed by:** _____ **Date:** _____

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. An estimate of the charge for any procedure or surgery you may require will be given to you. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company**. You will be responsible for all collection costs, attorney's fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* _____ **Date:** _____