Sarasota Dentistry

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Welcome to Sarasota Dentistry

The following pages include information that we need before performing treatment:
. 2-page health history
. 1-page photo consent
. 3-page privacy practices (HIPAA) - for you to keep
. 1-page HIPAA consent - sign acknowledging privacy practices
. 1-page consent to discuss - list anyone you would like us to be able to discuss your dental information with.

Office Policies
We believe in the theories of Modern Dental Care which do not support the old premise of "When it hurts fix it". Through proper preventive care and regular checkups, we believe that it is highly likely that most of our patients can expect to keep all of their teeth for all of their lives.

Our patients can expect from us:
1. A high degree of professional skill and ability.
2. A dedication to your oral health care.
3. A minimization of costly reconstructive work through proper preventative care.
4. The highest effort to make your visits as comfortable as possible.
5. The right treatment at the right time.
6. Fees that are fair and just for the services provided.
7. Open, honest, and respectful communication between you and the staff.

In return, we expect from our patients:
1. Cooperation in making and keeping appointments - 48 hours prior notification for a scheduling change.
2. A conscientious effort toward good oral hygiene.
3. Recall visits to maintain optimum oral health.
4. A definite arrangement for the payment of fees at the time of service.
5. Open, honest, and respectful communication between you and the staff.

We are looking forward to getting to know you, and if you have any questions or concerns about these forms, the office policies, or anything else, please feel free to contact us!

Sincerely,
Hank D. Michael, DMD

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the office policy above.**

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____

SS#: ___-__-____

Prev. Visit: _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____

Address 1 Address 2

_____ _____ _____-____

City State Zip Code

How did you hear about our office?

◯ Referral ◯ Google ◯ Yelp ◯ Facebook ◯ Postcard ◯ Phonebook ◯ Other

If a patient, whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**

I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges at time of service.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ You experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Have you ever whitened or bleached you teeth
☐ Have you experienced popping and/or clicking of your jaw joint
☐ You have difficulty chewing
☐ You clench or grind your teeth
☐ You wear or have worn a bite appliance
☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ Experienced gum recession
☐ Had any teeth become loose on their own (without injury)
☐ Experienced a burning sensation in your mouth
☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

Medical History

Physician's Name & Number (and Specialists; if applicable, i.e. Cardiologist, Oncologist)

Pharmacy Name & Number:

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ All Cillins
- ☐ Allergies- Seasonal
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Allergy- Metals
- ☐ Allergy- NSAIDS
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bisphosphonates
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Bruise/Bleed Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Epilepsy
- ☐ Frequent Headaches
- ☐ GAG Reflex
- ☐ Glaucoma
- ☐ Hard of Hearing
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Heart Valve
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Limited Opening
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Memory/.Dementia
- ☐ Mental Disorders
- ☐ Osteoporosis
- ☐ Other- Please List
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep apnea
- ☐ Smoker
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ - Pain Jaw Joint
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

Women, are you pregnant? ◯ Yes ◯ No

Women, are you taking birth control? ◯ Yes ◯ No

Current Medications: Please PRINT & INCLUDE DOSAGE

Please list any medications you are currently taking, one medication per line:

Please List Major Surgeries & Dates:

Please list any other conditions:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Photo Consent

Dental technology is constantly advancing, but one of the most recent advances is dental photography. Photography is critical to modern dental care. With a side by side comparison of a smile before and after the completion of any dental work, we are able to share our experiences with you, other dentists, and with patients considering procedures. Our office is proud to use two different digital cameras, intra-oral and extra-oral, which are displayed chairs-side during the exam and become an integral part of the patients permanent dental record and treatment planning. We take these photos on every patient but require your consent to use these photos in print, online, and video based marketing. By checking "yes" to the box below, you authorize us to use photos.

I hereby authorize photographs of my smile to be used in print or online for the purposes of education, communication, and/or promotion, of health-related information.

☐ Yes

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

Please list persons with whom we may discuss your information (and relationship):

_____

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: _____