# ORLANDO FAMILY & COSMETIC DENTISTRY

3191 Maguire Blvd, Suite #251 Orlando, Florida 32803 407-894-1451 phone 407-894-5656 fax

#### PATIENT INFORMATION

Legal Name of Patient			Nick	name	
Address		City	/	State_	Zip
Cell Phone#	Home#			Work#	
Date of Birth//	AgeSocial	Security#_		Sex	Male / Female
Driver's License#		State	Email		
Circle One: Minor Single Ma	arried Separated	Divorced	Widowed	Long-Term Par	tner
Employer			_Occupation	<u> </u>	
Who referred you to our office					
PRIMARY DENTAL INSUR Name of Insured		R	elationship t	o Patient	
Insured's address if different th	an above		City_	Stat	eZip
Cell Phone#	Home#			Work#	
Date of Birth//	Social Security#	<del>-</del>	;	Sex: Male / Fem	ale
Name of Insurance Company				Group#	
Address of Insurance Company			City	State	Zip
Subscriber I.D. # or Member #_			Toll Free	Phone # (	_)
Employer Name			_Occupation	1	
SECONDARY DENTAL INS Name of Insured		R	elationship t	o Patient	
Insured's address if different th	an above		<del> </del>	State_	Zip
Cell Phone#	Home#			Work#	
Date of Birth/	Social Security#		:	Sex: Male / Fem	ale
Name of Insurance Company_				Group#	
Address of Insurance Company			City	State	Zip
Subscriber I.D. # or Member #_			Toll Free	Phone # (	.)
Employer Name			_Occupation	1	
Signature of Patient or Guard	lian			D	ate
Is Patient a Minor YES / NO	If Ves. Print Nar	ne of Pare	nt/Guardia	n	

#### **MEDICAL HISTORY**

Patient Name	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

Address State Zip Phone State Zip  Do you have any dental problems now? Yes If yes, please list Is there anything you would change about your smile or oral health? Yes If yes, please list  Are any of your teeth sensitive to: Hot or Cold? Yes Sweets? Yes Biting or Chewing? Yes Have you noticed any mouth odors or bad tastes? Yes  Do your gums bleed or hurt? Yes Have you noticed any loose teeth or change in your bite? Yes Have you ever had a "deep cleaning" or any type of periodontal treatment? Yes Do you smoke or chew tobacco? Yes Do you clench or grind your teeth while awake or asleep? Yes Do you or have you experienced popping or clicking of the jaw? Yes Are you reeth yellow or heavily stained? Yes Are you interested in tooth whitening? Yes Are you interested in tooth whitening? Yes Are you interested in tooth whitening? Yes					
Previous Dentist's Name	Date of Last Dental Visit	Last Dental Cleaning	Last Full Mou	th X-rays	
Address State Zip Phone State Zip  Do you have any dental problems now? Yes If yes, please list Is there anything you would change about your smile or oral health? Yes If yes, please list  Are any of your teeth sensitive to: Hot or Cold? Yes Sweets? Yes Biting or Chewing? Yes Have you noticed any mouth odors or bad tastes? Yes  Do your gums bleed or hurt? Yes Have you noticed any loose teeth or change in your bite? Yes Have you ever had a "deep cleaning" or any type of periodontal treatment? Yes Do you smoke or chew tobacco? Yes Do you clench or grind your teeth while awake or asleep? Yes Do you or have you experienced popping or clicking of the jaw? Yes Are you reeth yellow or heavily stained? Yes Are you interested in tooth whitening? Yes Are you interested in tooth whitening? Yes Are you interested in tooth whitening? Yes					
Do you have any dental problems now?  If yes, please list  Is there anything you would change about your smile or oral health?  If yes, please list  Are any of your teeth sensitive to:  Hot or Cold?  Sweets?  Biting or Chewing?  Have you noticed any mouth odors or bad tastes?  Po your gums bleed or hurt?  Have you noticed any loose teeth or change in your bite?  Does food tend to become caught in between your teeth?  Have you ever had a "deep cleaning" or any type of periodontal treatment?  Pes  Do you smoke or chew tobacco?  Yes  Do you clench or grind your teeth while awake or asleep?  Do you or have you experienced popping or clicking of the jaw?  Yes  Are your teeth yellow or heavily stained?  Yes  Are you interested in tooth whitening?  Yes	Address		State	Zip	
If yes, please list Is there anything you would change about your smile or oral health?  If yes, please list  Are any of your teeth sensitive to:  Hot or Cold?  Sweets?  Biting or Chewing?  Have you noticed any mouth odors or bad tastes?  Yes  Do your gums bleed or hurt?  Have you noticed any loose teeth or change in your bite?  Does food tend to become caught in between your teeth?  Have you ever had a "deep cleaning" or any type of periodontal treatment?  Yes  Do you smoke or chew tobacco?  Yes  Do you clench or grind your teeth while awake or asleep?  Do you or have you experienced popping or clicking of the jaw?  Yes  Are your teeth yellow or heavily stained?  Yes  Are you interested in tooth whitening?  Yes	Phone				
Is there anything you would change about your smile or oral health?	Do you have any dental problems	now?		Yes	No
Is there anything you would change about your smile or oral health?	If yes, please list				
Are any of your teeth sensitive to:  Hot or Cold?	Is there anything you would chang	e about your smile or oral healt	th?	Yes	No
Hot or Cold? Yes Sweets? Yes Biting or Chewing? Yes Botyour gums bleed or hurt? Yes Have you noticed any loose teeth or change in your bite? Yes Does food tend to become caught in between your teeth? Yes Have you ever had a "deep cleaning" or any type of periodontal treatment? Yes Do you smoke or chew tobacco? Yes  Do you clench or grind your teeth while awake or asleep? Yes Do you or have you experienced popping or clicking of the jaw? Yes Are your teeth yellow or heavily stained? Yes Are you interested in tooth whitening? Yes	If yes, please list				
Sweets? Yes Biting or Chewing? Yes Have you noticed any mouth odors or bad tastes? Yes  Do your gums bleed or hurt? Yes Have you noticed any loose teeth or change in your bite? Yes Does food tend to become caught in between your teeth? Yes Have you ever had a "deep cleaning" or any type of periodontal treatment? Yes Do you smoke or chew tobacco? Yes  Do you clench or grind your teeth while awake or asleep? Yes Do you or have you experienced popping or clicking of the jaw? Yes Are your teeth yellow or heavily stained? Yes Are you interested in tooth whitening? Yes					
Biting or Chewing? Yes Have you noticed any mouth odors or bad tastes? Yes  Do your gums bleed or hurt? Yes Have you noticed any loose teeth or change in your bite? Yes Does food tend to become caught in between your teeth? Yes Have you ever had a "deep cleaning" or any type of periodontal treatment? Yes Do you smoke or chew tobacco? Yes  Do you clench or grind your teeth while awake or asleep? Yes Do you or have you experienced popping or clicking of the jaw? Yes Are your teeth yellow or heavily stained? Yes Are you interested in tooth whitening? Yes	Hot or Cold?			Yes	No
Have you noticed any mouth odors or bad tastes?					No
Do your gums bleed or hurt?					No
Have you noticed any loose teeth or change in your bite?	Have you noticed any mouth odor	s or bad tastes?		Yes	No
Does food tend to become caught in between your teeth?	Do your gums bleed or hurt?			Yes	No
Have you ever had a "deep cleaning" or any type of periodontal treatment?	Have you noticed any loose teeth	or change in your bite?		Yes	No
Do you smoke or chew tobacco?					No
Do you clench or grind your teeth while awake or asleep?					No
Do you or have you experienced popping or clicking of the jaw?	Do you smoke or chew tobacco?			Yes	No
Do you or have you experienced pain in your jaw?	Do you clench or grind your teeth	while awake or asleep?		Yes	No
Are your teeth yellow or heavily stained?	Do you or have you experienced p	opping or clicking of the jaw?		Yes	No
Are you interested in tooth whitening?Yes	Do you or have you experienced p	ain in your jaw?		Yes	No
	Are your teeth yellow or heavily s	tained?		Yes	No
Are you unhappy with the alignment of your teeth?Yes	Are you interested in tooth whiter	iing?		Yes	No
	Are you unhappy with the alignme	ent of your teeth?		Yes	No
With respect to your past dental experience; Is there anything we should repeat or avoid? Is there anythin	With respect to your past dental e	xperience; Is there anything we	e should repeat or avoid	d? Is there anyth	ning
that happened in another dental office we should be sensitive to? Is there anything else we can do to make					
you more comfortable?					

### **MEDICAL HISTORY**

1.) Have you been under the care of a medical doctor during the past two years?	Pati	ent Name				Medical	Alert				
If yes, for what?  Physician's Name  Address  City  State  Zip  2.) Are you taking any medication, drugs, or pills now?  "If yes, please list on the BOTTOM of this form  3.) Are you aware of having an allergic (or adverse reaction) to any medication or substance?  (Yes)  No if yes, please list;  4.) Have you been a patient in the hospital during the past five years?  (Yes)  No if yes, please explain;  5.) Indicate which of the following you have had, or have at the present. Circle "V"es or "N"o to each item.  Heart Gurgery, Disease, Attack) Y N Uicers  Y N Hepatitis A(Infectious)B(Serum)Y N Chest Pain Y N Diabetes  Y N Venereal Disease  Y N Venereal Disease  Y N Venereal Disease  Y N Heart Murmur  Y N Glaucoma  Y N H.I.V. Positive  Y N Heart Murmur  Y N Glaucoma  Y N H.I.V. Positive  Y N Heart Murmur  Y N Glaucoma  Y N H.I.V. Positive  Y N ALD.S.  Mittral Valve Prolapse  Y N Contact Lenses  Y N Cold Sores/Fever Blisters Y N ALD.S.  Artificial Heart Valve  Y N Tuberculosis  Y N Sickle Cell Disease  Y N Remarks Free Medicine  Y N Have Free Medicine  Y N Asthma  Y N Bruse Easy  Y N Sickle Cell Disease  Y N N Diet (Special/restricted)  Y N Asthma  Y N Hay Fever  Y N Liver Disease  Y N N Neurological Disorders  Y N Sirole  Y N Sirole  Y N N Hermophilia  Y N N Have Seasy  Y N N Neurological Disorders  Y N Sirole  Y N N Hermophilia  Y N N Perous/Annoius  Y N Sirole  Y N N Hermophilia  Y N N Perous/Annoius  Y N N Sirole  Y N Perpenant? Ves, Months No Nursing? Yes No Taking birth control pills? Ves No If yes, please list.  Poper medicate with an antibiotic prior to any kind of dental treatment?  Pes No If yes, please list:    I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release	1.)	Have you been under the car	e of	a me	dical doctor durir	ng the past	t two ye	ears?		Yes	No
Physician's Name	,	•				•	•				
Address										-	
2.) Are you taking any medication, drugs, or pills now?											
**If yes, please list on the BOTTOM of this form 3. Are you aware of having an allergic (or adverse reaction) to any medication or substance?	21										No
3.) Are you aware of having an allergic (or adverse reaction) to any medication or substance?	۷٠,					••••••		•••••			140
4.) Have you been a patient in the hospital during the past five years?	2 \	• •				•) +o onu n	n a disati	ion o	r substance?	Voc	Na
4.) Have you been a patient in the hospital during the past five years?	3.)	•	_	-		•				res	NO
If yes, please explain;  Indicate which of the following you have had, or have at the present. Circle "Y"es or "N"o to each item.  Heart (Surgery, Disease, Attack) Y N Ulcers Y N Hepatitis A(Infectious)B(Serum)Y N Chest Pain Y N Diabetes Y N Venereal Disease Y N Congenital Heart Disease Y N Thyroid Problems Y N A.I.D.S. Y N Heart Murmur Y N Glaucoma Y N H.I.V. Positive Y N High Blood Pressure Y N Contact Lenses Y N Cold Sorres/Fever Blisters Y N Mitral Valve Prolapse Y N Emphysema Y N Blood Transfusion Y N Artificial Heart Valve Y N Chronic Cough Y N Hemophilia Y N Heart Pacemaker Y N Tuberculosis Y N Sickle Cell Disease Y N Artificial Heart Valve Y N Tuberculosis Y N Sickle Cell Disease Y N Arthritis/Rheumatism Y N Hay Fever Y N Liver Disease Y N Cortisone Medicine Y N Latex Sensitivity Y N Yellow Jaundice Y N Stroke Y N Altergies or Hives Y N Neurological Disorders Y N Stroke Y N Sinus Trouble Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip, Knee, Etc.) Y N Chemotherapy Y N Fainting or Dizzy Spells Y N N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N Nifferial Joints (Hip, Knee, Etc.) Y N Chemotherapy Y N Psychiatric/Psychological Care Y N Nour Pregnant? Yes, Months No Nursing? Yes No Taking birth control pills? Yes No I Judges list:  I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATURE DATE		ii yes, piease iist;								-	
If yes, please explain;  Indicate which of the following you have had, or have at the present. Circle "Y"es or "N"o to each item.  Heart (Surgery, Disease, Attack) Y N Ulcers Y N Hepatitis A(Infectious)B(Serum)Y N Chest Pain Y N Diabetes Y N Venereal Disease Y N Congenital Heart Disease Y N Thyroid Problems Y N A.I.D.S. Y N Heart Murmur Y N Glaucoma Y N H.I.V. Positive Y N High Blood Pressure Y N Contact Lenses Y N Cold Sorres/Fever Blisters Y N Mitral Valve Prolapse Y N Emphysema Y N Blood Transfusion Y N Artificial Heart Valve Y N Chronic Cough Y N Hemophilia Y N Heart Pacemaker Y N Tuberculosis Y N Sickle Cell Disease Y N Artificial Heart Valve Y N Tuberculosis Y N Sickle Cell Disease Y N Arthritis/Rheumatism Y N Hay Fever Y N Liver Disease Y N Cortisone Medicine Y N Latex Sensitivity Y N Yellow Jaundice Y N Stroke Y N Altergies or Hives Y N Neurological Disorders Y N Stroke Y N Sinus Trouble Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip, Knee, Etc.) Y N Chemotherapy Y N Fainting or Dizzy Spells Y N N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N Nifferial Joints (Hip, Knee, Etc.) Y N Chemotherapy Y N Psychiatric/Psychological Care Y N Nour Pregnant? Yes, Months No Nursing? Yes No Taking birth control pills? Yes No I Judges list:  I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATURE DATE										-	
If yes, please explain;  Indicate which of the following you have had, or have at the present. Circle "Y"es or "N"o to each item.  Heart (Surgery, Disease, Attack) Y N Ulcers Y N Hepatitis A(Infectious)B(Serum)Y N Chest Pain Y N Diabetes Y N Venereal Disease Y N Congenital Heart Disease Y N Thyroid Problems Y N A.I.D.S. Y N Heart Murmur Y N Glaucoma Y N H.I.V. Positive Y N High Blood Pressure Y N Contact Lenses Y N Cold Sorres/Fever Blisters Y N Mitral Valve Prolapse Y N Emphysema Y N Blood Transfusion Y N Artificial Heart Valve Y N Chronic Cough Y N Hemophilia Y N Heart Pacemaker Y N Tuberculosis Y N Sickle Cell Disease Y N Artificial Heart Valve Y N Tuberculosis Y N Sickle Cell Disease Y N Arthritis/Rheumatism Y N Hay Fever Y N Liver Disease Y N Cortisone Medicine Y N Latex Sensitivity Y N Yellow Jaundice Y N Stroke Y N Altergies or Hives Y N Neurological Disorders Y N Stroke Y N Sinus Trouble Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip, Knee, Etc.) Y N Chemotherapy Y N Fainting or Dizzy Spells Y N N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N Nifferial Joints (Hip, Knee, Etc.) Y N Chemotherapy Y N Psychiatric/Psychological Care Y N Nour Pregnant? Yes, Months No Nursing? Yes No Taking birth control pills? Yes No I Judges list:  I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATURE DATE										-	
S.   Indicate which of the following you have had, or have at the present.   Circle "Y"es or "N"o to each item.	4.)			-		-				Yes	No
Heart (Surgery, Disease, Attack) Y N Ulcers Y N Hepatitis A (Infectious) B (Serum) Y N Chest Pain Y N Diabetes Y N Venereal Disease Y N											
Chest Pain Y N Diabetes Y N Venereal Disease Y N Congenital Heart Disease Y N Thyroid Problems Y N A.I.D.S. Y N Heart Murmur Y N Glaucoma Y N H.I.V. Positive Y N High Blood Pressure Y N Contact Lenses Y N Cold Sores/Fever Blisters Y N Mitral Valve Prolapse Y N Emphysema Y N Blood Transfusion Y N Artificial Heart Valve Y N Chronic Cough Y N Hemophilia Y N Heart Pacemaker Y N Tuberculosis Y N Stoke Y N Stoke Y N Asthma Y N Bruise Easy Y N Arthritis/Rheumatism Y N Hay Fever Y N Asthma Y N Bruise Easy Y N Arthritis/Rheumatism Y N Hay Fever Y N Liver Disease Y N Stoke N N Stoke Y N N Stoke Y N Stoke Y N N N N N N N N N N N N N N N N N N	5.)	Indicate which of the following	ıg yo	ou ha	ve had, or have a	t the prese	ent. <b>Cir</b>	cle "	Y"es or "N"o to each item.		
Congenital Heart Disease		Heart (Surgery, Disease, Attacl	() Y	Ν	Ulcers		Υ	Ν	Hepatitis A(Infectious)B(Se	erum)Y	N
Heart Murmur Y N Glaucoma Y N H.I.V. Positive Y N High Blood Pressure Y N Contact Lenses Y N Cold Sores/Fever Blisters Y N Mitral Valve Prolapse Y N Emphysema Y N Blood Transfusion Y N Hemophilia Y N Artificial Heart Valve Y N Chronic Cough Y N Hemophilia Y N Heart Pacemaker Y N Tuberculosis Y N Sickle Cell Disease Y N Rheumatic Fever Y N Asthma Y N Bruise Easy Y N Arthritis/Rheumatism Y N Hay Fever Y N Liver Disease Y N Arthritis/Rheumatism Y N Hay Fever Y N Liver Disease Y N Soullen Ankles Y N Allergies or Hives Y N Neurological Disorders Y N Stroke Y N Sinus Trouble Y N Epilepsy or Seizures Y N Diet (special/restricted) Y N Radiation Therapy Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip,Knee,Etc.) Y N Chemotherapy Y N Psychiatric/Psychological Care Y N If yes, please list:  7. Do you or have you had any disease, condition, or problem not listed Yes, please list:  7. Do you pre-medicate with an antibiotic prior to any kind of dental treatment? Yes No If yes, please list:  7. Do you pre-medicate with an antibiotic prior to any kind of dental treatment? Wes No Itaking birth control pills? Yes No Itaking birth control p		Chest Pain	Υ	N	Diabetes		Υ	N	Venereal Disease		
High Blood Pressure Y N Contact Lenses Y N Cold Sores/Fever Blisters Y N Mitral Valve Prolapse Y N Emphysema Y N Blood Transfusion Y N Artificial Heart Valve Y N Chronic Cough Y N Hemophilia Y N Hemophilia Y N Representation of the Process of the		Congenital Heart Disease	Υ	Ν	Thyroid Problem	าร	Υ	N	A.I.D.S.	Υ	N
Mitral Valve Prolapse Y N Emphysema Y N Blood Transfusion Y N Artificial Heart Valve Y N Chronic Cough Y N Hemophilia Y N Heart Pacemaker Y N Tuberculosis Y N Sickle Cell Disease Y N Rheumatic Fever Y N Asthma Y N Bruse Easy Y N Arthritis/Rheumatics Y N Hay Fever Y N Liver Disease Y N Cortisone Medicine Y N Latex Sensitivity Y N Liver Disease Y N Cortisone Medicine Y N Latex Sensitivity Y N Yellow Jaundice Y N Swollen Ankles Y N Allergies or Hives Y N Neurological Disorders Y N Stroke Y N Sinus Trouble Y N Epilepsy or Seizures Y N Diet (special/restricted) Y N Radiation Therapy Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip,Knee,Etc.) Y N Chemotherapy Y N Psychiatric/Psychological Care Y N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N N If yes, please list: 7.) Do you or have you had any disease, condition, or problem not listed Yes, please list: 7.) Do you pre-medicate with an antibiotic prior to any kind of dental treatment? 8.) WOMEN Are you: Pregnant? Yes,Months No Nursing? Yes No Taking birth control pills? Yes No LIST OF MEDICATIONS; **    REVIEW OF MEDICAL HISTORY (FOR OFFICE USE ONLY)		Heart Murmur	Υ	N	Glaucoma		Υ	N	H.I.V. Positive	Υ	Ν
Artificial Heart Valve Y N Chronic Cough Y N Hemophilia Y N Heart Pacemaker Y N Tuberculosis Y N Sickle Cell Disease Y N Rheumatic Fever Y N Asthma Y N Bruise Easy Y N Arthritis/Rheumatism Y N Hay Fever Y N Liver Disease Y N Arthritis/Rheumatism Y N Hay Fever Y N Liver Disease Y N Cortisone Medicine Y N Latex Sensitivity Y N Yellow Jaundice Y N Swollen Ankles Y N Allergies or Hives Y N Neurological Disorders Y N Stroke Y N Sinus Trouble Y N Epilepsy or Seizures Y N Diet (special/restricted) Y N Radiation Therapy Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip,Knee,Etc.) Y N Chemotherapy Y N Radiation Therapy Y N Psychiatric/Psychological Care Y N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N If yes, please list:  7.) Do you or have you had any disease, condition, or problem not listed Yes, please list:  7.) Do you pre-medicate with an antibiotic prior to any kind of dental treatment? Yes No Taking birth control pills? Yes No Nursing? Yes No Taking birth control pills? Yes No LIST OF MEDICATIONS;  ***  **REVIEW OF MEDICAL HISTORY**  **FREVIEW O		High Blood Pressure	Υ	Ν	Contact Lenses		Υ	Ν	Cold Sores/Fever Blisters	Υ	N
Heart Pacemaker    Y		Mitral Valve Prolapse	Υ	N	Emphysema		Υ	Ν	Blood Transfusion	Υ	Ν
Rheumatic Fever Y N Asthma Y N Bruise Easy Y N Arthritis/Rheumatism Y N Hay Fever Y N Liver Disease Y N Cortisone Medicine Y N Latex Sensitivity Y N Yellow Jaundice Y N Swollen Ankles Y N Allergies or Hives Y N Neurological Disorders Y N Swollen Ankles Y N Sinus Trouble Y N Epilepsy or Seizures Y N Diet (special/restricted) Y N Radiation Therapy Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip,Knee,Etc.) Y N Chemotherapy Y N Nervous/Anxious Y N Kidney Trouble Y N Tumors Y N Nervous/Anxious Y N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N 6.) Do you or have you had any disease, condition, or problem not listed		Artificial Heart Valve	Υ	N	Chronic Cough		Υ	N	Hemophilia	Υ	N
Arthritis/Rheumatism Y N Hay Fever Y N Liver Disease Y N Cortisone Medicine Y N Latex Sensitivity Y N Yellow Jaundice Y N Swollen Ankles Y N Latex Sensitivity Y N Neurological Disorders Y N Stroke Y N Sinus Trouble Y N Epilepsy or Seizures Y N Diet (special/restricted) Y N Radiation Therapy Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip,Knee,Etc.) Y N Chemotherapy Y N Nervous/Anxious Y N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N N Do you or have you had any disease, condition, or problem not listed		Heart Pacemaker	Υ	Ν	Tuberculosis		Υ	Ν	Sickle Cell Disease	Υ	Ν
Cortisone Medicine Y N Latex Sensitivity Y N Yellow Jaundice Y N Swollen Ankles Y N Allergies or Hives Y N Neurological Disorders Y N Stroke Y N Sinus Trouble Y N Epilepsy or Seizures Y N Diet (special/restricted) Y N Radiation Therapy Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip,Knee,Etc.) Y N Chemotherapy Y N Nervous/Anxious Y N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N Do you or have you had any disease, condition, or problem not listed		Rheumatic Fever	Υ	Ν	Asthma		Υ	N	Bruise Easy		
Swollen Ankles Y N Allergies or Hives Y N Neurological Disorders Y N Stroke Y N Sinus Trouble Y N Epilepsy or Seizures Y N Diet (special/restricted) Y N Radiation Therapy Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip,Knee,Etc.) Y N Chemotherapy Y N Nervous/Anxious Y N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N Do you or have you had any disease, condition, or problem not listed			Υ	N	•			N			
Stroke Y N Sinus Trouble Y N Epilepsy or Seizures Y N Diet (special/restricted) Y N Radiation Therapy Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip,Knee,Etc.) Y N Chemotherapy Y N Nervous/Anxious Y N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N 6.) Do you or have you had any disease, condition, or problem not listed					•						
Diet (special/restricted) Y N Radiation Therapy Y N Fainting or Dizzy Spells Y N Artificial Joints (Hip,Knee,Etc.) Y N Chemotherapy Y N Nervous/Anxious Y N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N O. Do you or have you had any disease, condition, or problem not listed		Swollen Ankles	Υ	N		!S	Υ	N		Y	N
Artificial Joints (Hip,Knee,Etc.) Y N Chemotherapy Y N Nervous/Anxious Y N Kidney Trouble Y N Tumors Y N Psychiatric/Psychological Care Y N Do you or have you had any disease, condition, or problem not listed				N							
Kidney Trouble  Y N Tumors  Y N Psychiatric/Psychological Care Y N  6.) Do you or have you had any disease, condition, or problem not listed						ру					
If yes, please list:											
If yes, please list:		Kidney Trouble	Υ	N	Tumors		Y	N	Psychiatric/Psychological (	Care Y	N
7.) Do you pre-medicate with an antibiotic prior to any kind of dental treatment?	6.)	Do you or have you had any o	lisea	ise, c	ondition, or prob	lem not lis	sted			Yes	No
8.) WOMEN Are you: Pregnant? Yes,Months No Nursing? Yes No Taking birth control pills? Yes No  LIST OF MEDICATIONS; **  REVIEW OF MEDICAL HISTORY (FOR OFFICE USE ONLY)		If yes, please list:									
LIST OF MEDICAL HISTORY (FOR OFFICE USE ONLY)  I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATURE  DATE  DATE	7.)	Do you <b>pre-medicate</b> with an	ant	ibiot	ic prior to any kin	d of denta	al treatn	nentî	?	Yes	No
I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATURE	8.)	WOMEN Are you: Pregnan	t? Y	es, _	Months No	Nursing?	? Yes	No	Taking birth control pills?	Yes	No
I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATURE											
I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATURE	LIS	T OF MEDICATIONS; **				REVIEV	V OF M	IEDI(	CAL HISTORY (FOR OFFICE U	SE ONLY	<u>.                                    </u>
I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATURE											
I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATURE											
have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATUREDATEDATE											
have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATUREDATEDATE											
have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATUREDATEDATE		- d	• :						in a sefe and efficient man		
permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATUREDATEDATE					• •						
notify the doctor of any changes in my health or medication.  PATIENT/GUARDIAN SIGNATUREDATEDATE											
PATIENT/GUARDIAN SIGNATUREDATE							o may f	CIEd	se such hilorination to you.	ı WIII	
				-					DATE		
DENTIST SIGNATURE	17								D/\\\L		
	DF	NTIST SIGNATURF							DATF		

### ORLANDO FAMILY & COSMETIC DENTISTRY

3191 Maguire Blvd Suite 251 Orlando, Florida 32803

#### FINANCIAL POLICY

We are pleased that you have selected us as your dental care provider. For your knowledge, our Financial Policy is outlined below.

**Promise to Pay.** Amounts for dental care services provided to you or your family members may be charged to your Account, unless you specifically instruct us otherwise. You promise to pay us all amounts owed on your Account (your "Balance") under the terms of this Financial Policy when billed. If you have dental insurance, the amount you owe for services may be estimated based on the amount anticipated to be paid by your insurance company. We will assist you with a dental insurance claim as long as the correct insurance information is given before time of service. If there is a change in insurance we ask you provide us with the updated information 24 hours in advance. We do not accept or file Medical Insurance. If you have a secondary insurance you will be expected to pay your portion based on your primary insurance only. As a courtesy we will help you file your secondary insurance claim, but the payment will be made directly to the insured member of the secondary insurance. Insurance is a contract between the policy holder and insurance company. The anticipated amount to be paid by your insurance company may be charged to your account until we receive payment from your insurance company. However, in the event your insurance company is slow to pay or disallows a claim, payment of your Account is your full responsibility. We may also charge to your Account fees set forth below for missed appointments, late payments, returned payments or collection costs. We will provide to you a statement (your "Statement") of your Balance, which will be payable when you receive your Statement. We may indicate on your Statement that your Balance is "pending insurance" and thus not yet payable by you. If you have insurance coverage, we may choose not to send you a Statement until we know or receive the amount reimbursable by your insurance company.

**Missed Appointment Fee.** We may charge to your Account fees of \$50/Hour for a missed appointment or fees for an appointment cancelled without advance notice of <u>at least 48 hours</u>.

Late Payment Fee. If we do not receive payment in full of your Balance within 30 days of the statement date shown on your Statement, you will be assessed a Late Payment Fee of \$10.00 for each month your full Balance goes unpaid. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your Balance. Returned Payment Fee. If any check or other payment that you have made on your Account is returned unpaid, you will be charged a Returned Payment Fee, which is currently \$35.00 and may be adjusted due to fluctuating bank charges. Collection Cost. If we do not receive payment under the terms of this Financial Policy and we refer your Account to a collection agency or an attorney for collection, we may charge to your Account or otherwise collect from you our collection costs, including court costs and reasonable attorneys' fees, to the extent not prohibited by applicable law.

No Waiver by Us. We may waive our right to charge a fee to your Account without waiving any other right we have under this Financial Policy including our right to charge that same fee at any other time.

**Communications.** By signing this policy you are consenting to allowing our office to communicate with you via phone, text, email, & mail. This communication can include but is not limited to your patient records, receipts and promotional matters such as marketing.

**Credit Reports.** We, or a collection agency or attorney acting on our behalf, may report late payments, missed payments or other defaults on your account to credit reporting agencies. If you believe that we have information about you that is inaccurate or that we have reported or may report inaccurate information to a collection agency, please notify us of the specific information that you believe is inaccurate by writing to us at the address above.

As used in this Financial Policy, "we," "us," "our" and "Provider" mean the service provider named above (Orlando Family & Cosmetic Dentistry). "Services" means any services provided by us. "You," "your' and "Account holder" mean the person responsible for paying for services. Payment for services is due when services are provided unless as noted otherwise above. By signing below, you are requesting that we establish an open account for you (your "Account") as an accommodation to you for the tracking and payment of amounts due and you agree to the terms of this Financial Policy.

Yes, I agree to the above terms and conditions.

Account Holder's Signature	Print Name	Date

# **ORLANDO FAMILY & COSMETIC DENTISTRY**

## ACKNOWLEDGEMENT OF RECEIPT OF OUR PRIVACY PRACTICES (HIPAA) AND OFFICE POLICIES

I,				
Please Print Name				
Signature				
Date				
If you would like to permit our office to spea named, regarding your treatment please list	· · · · · · · · · · · · · · · · · · ·			