WESTON Dental Care
Revitalize your smile

Chart #: ___________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ Date: ___________
Last, First MI (Preferred Name)
Gender: ______________ Marital Status: ______________

Social Security #: ________ Email: Birth Date: _________

Phone (Home): ______________ (Work): ______________ Ext: ________ (Cell): ______________

Email: ____

Address: ____
Street Apartment #
____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ SS #: ______________ Group #: ______________ ID #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Dental Ins. CO and Address: ____
____
____

Person to Contact in case of emergency:
Name______________________ Relationship______________ Telephone # ______________

Has any member of your family ever been treated in our office? ☐ Yes ☐ No Name: ______________

Whom may we thank for referring you to our office? ______________________

Health Information

DENTAL HISTORY :

Primary reason for this dental visit: ☐ Examination ☐ Emergency ☐ Consultation

Do you have a specific dental problem? Describe ______________________ ☐ Yes ☐ No
Do you have dental examinations on a routine basis? Date of Last Dental Visit: ______________ ☐ Yes ☐ No
Do you think you have active decay or gum disease? ______________________ ☐ Yes ☐ No
Do you brush and floss on a routine basis? Discuss ______________________ ☐ Yes ☐ No
Do your gums ever bleed? Discuss ______________________ ☐ Yes ☐ No
Do you like your smile? Why? Discuss ______________________ ☐ Yes ☐ No
Does food catch between your teeth? Any loose teeth? ______________________ ☐ Yes ☐ No
Do you want to keep your remaining teeth? Discuss ______________________ ☐ Yes ☐ No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ______________ ☐ Yes ☐ No
Have your past experiences in a dental office always been positive? ______________________ ☐ Yes ☐ No

Have you ever had any complications following dental treatment? Explain ________________________________ ☐ Yes ☐ No
Do you smoke or chew? Any sores or growths in your mouth? Discuss ___________________________________ ☐ Yes ☐ No
Name of previous dentist (optional): _________________________
Date of last full mouth x-rays (16 small films or panoramic): __________________________

MEDICAL HISTORY :

Are you under a physician's care now? Why? ____ ☐ Yes ☐ No
If yes, please specify: Physician's name ____ Physician's phone:______________
Have you ever been hospitalized or had a major operation? Explain _____________________________________ ☐ Yes ☐ No
Have you ever had a serious injury to your head or neck? Explain _______________________________________ ☐ Yes ☐ No
Are you taking any medications, pills or drugs? What? ____________ _____________________________________ ☐ Yes ☐ No
Are you on a special diet? Discuss ________________________ _____________________________________ ☐ Yes ☐ No
Are you taking allergic to any medications or substances? Please check below ____________________________ ☐ Yes ☐ No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other

Have you ever had any of the following? Please check those that apply:

- ☐ Heart Disease/Surgery *
- ☐ Heart Murmur *
- ☐ Irregular Heartbeat
- ☐ Angina/Chest Pain
- ☐ Heart Attack / Failure
- ☐ Congenital Heart Disorder
- ☐ Mitral Valve Prolapse *
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Artificial Heart Valve *
- ☐ Heart Pace Maker *
- ☐ Pulmonary Shunt
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Bacterial Endocarditis
- ☐ Unexplained fever
- ☐ Bruise Easily /Blood Disease
- ☐ Anemia
- ☐ Excessive Bleeding
- ☐ Sickle Cell Disease
- ☐ Hemophilia (Bleeding Problem)
- ☐ Leukemia
- ☐ Recent Blood Transfusion
- ☐ Swelling of Limbs

- ☐ Lung Disease
- ☐ Breathing problem
- ☐ Shortness of Breath
- ☐ Frequent Cough
- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Bloody Sputum
- ☐ Night Sweats
- ☐ Yellow Jaundice
- ☐ Kidney Problems
- ☐ Renal Dialysis
- ☐ Thyroid Disease
- ☐ Parathyroid Disease
- ☐ Arthritis / Gout
- ☐ Rheumatism
- ☐ Pain in Jaw Joints
- ☐ Cortisone Mmedicine
- ☐ Artificial Joint *
- ☐ Venereal Disease
- ☐ AIDS
- ☐ HIV Positive
- ☐ Genital Herpes
- ☐ Drug Addiction / Alcoholism
- ☐ Tattoos/Body Piercing

- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Cancer
- ☐ X-Ray Treatment (Radiation)
- ☐ Chemotherapy
- ☐ Aredia I.V.
- ☐ Zometa I.V.
- ☐ Stomach /Intestinal disease
- ☐ Ulcers
- ☐ Recent Weight loss
- ☐ Frequent Diarrhea
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Hypoglycemia
- ☐ Liver Disease
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B or C

- ☐ Pregnancy
  Due date:_________

- ☐ Penicillin Allergy

- ☐ Cold Sores
- ☐ Fever Blisters
- ☐ Herpes
- ☐ Stroke
- ☐ Convulsions
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Tumors or Growths
- ☐ Mental Disorders
- ☐ Nervousness
- ☐ Psychiatric Care
- ☐ Alzheimer's Disease
- ☐ Allergies (medicines)__________
- ☐ Allergies (Pollen /Dust)
- ☐ Hives or Rash
- ☐ Head Injuries

- ☐ Need Premedication? *
- ☐ Ever Taken Fen-phen?*

OTHER:
- ☐ ________________
- ☐ ________________

Do you have any disease, condition, or problem not listed previously that you feel we should know about? ☐ Yes ☐ No
If yes, please describe: ____________________________________
Do you wish to talk to the dentist privately about any other problem? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ____________________
Signature of patient, parent or guardian

Reviewed by Doctor ______________________________ Date ________________ BP____________ Pulse___________
History Review and Significant Findings____
____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best time to call: ____________

Address: ____

Street Apartment #

____

City State Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
I understand that I am responsible for all costs of professional services rendered and fees regardless of insurance coverage.
I hereby authorize payment directly to Weston Dental Care of the group insurance benefits otherwise payable to me.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand my signature authorizes releasing of the information to the insurer or agency given to Weston Dental Care for participating health insurance plans.

I hereby authorize Weston Dental Care to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this form and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medicine histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.
A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party

WESTON DENTAL CARE
2235 N COMMERCE PARKWAY, SUITE 1
WESTON, FL 33326
(954) 389 1212

Consent For Use and Disclosure of Health Information (HIPAA)

Section A: Patient Giving Consent
Name of Patient:____

Section B: PATIENTS PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to:
Conduct, plan and direct your treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
Obtain payment from third-party payers.
Conduct normal health care operations such as quality assessments and physician certifications.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice is available at your request in our office. We encourage you to request a copy and read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may request a copy of our Notice of Privacy Practices, including any revisions of our Notice, at our front desk.

Right to Revoke: You will have the right to revoke this Consent at any time by providing our office with a written notice of your revocation at our front desk. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Section C:
Consent: I, the patient and/or representative*, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:____Date:______________
* If this Consent is signed by a personal representative on behalf of the patient, please complete the following:
Personal Representative Name: ____
Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.