Öentist 4
better quality of life

Better bites, better smiles, better life.

PATIENT INFORMATION

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Gender: ☐ Female ☐ Male **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ **SS#:** _____ **Emergency Contact:** _____ (Name) _____ (Phone)

Phone: _____ (Home) _____ (Mobile) **E-Mail:** _____

Address: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

RESPONSIBLE PARTY INFORMATION

Has there been any changes with your insurance in the last 12 months?

Yes No If yes, please provide us the new insurance information: _____

MEDICAL INFORMATION:

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you been admitted to a hospital or needed emergency care during the past 2 years?

☐ Yes ☐ No If yes, please explain: _____

Are you pregnant, nursing, or do you think you might be pregnant?

☐ Yes ☐ No

Have you had any changes in your health conditions?

☐ Yes ☐ No If yes, please explain: _____

Have you had any changes in your allergies?

☐ Yes ☐ No If yes, please explain: _____

List all medications you are currently taking (prescription and non-prescription): _____

CONSENT FOR SERVICES AND FINANCIAL POLICY:

I acknowledge that I have reviewed this form and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify Sunshine Dental Center of any future changes. As a condition of treatment by this office, financial arrangements must be made in advance. Sunshine Dental Center depends upon reimbursement from patients for the costs incurred in their care. 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 unless other arrangements are made.
Patients with dental insurance understand that all dental services are charged to the patient and that he or she is personally responsible for payment of all dental services. Sunshine Dental Center will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any 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. A service of 1.5% 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 any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. I understand that in case a refund is required, it will take between 2 and 3 business days.
In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

_____ Relationship to Patient: _____ Date: _____

Signature of patient, parent/guardian, or responsible party

SUNSHINE DENTAL CENTER
1711 Hammondville Rd, Pompano Beach, Fl 33069 / 2331 N State Rd 7, Ste 109-110, Lauderhill, Fl 33313
Tel: 954-972-6066 / 954-486-6989 / E-Mail: contact@sunshinedentalcenter.us

Dentist 4
better quality of life

Better bites, better smiles, better life.

Have you had any recent surgery, pins, rood, or stents?

☐ Yes ☐ No If yes, please explain: _____

Are you tired upon awakening from sleep or during the day?

☐ Yes ☐ No

Do you have headaches in the morning?

☐ Yes ☐ No

Indicate which of the following conditions you have or have had. Please check those that apply:

☐ Anemia	☐ Angina	☐ Arteriosclerosis	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Autoimmune Disease	☐ Blood Disease
☐ Blood Thinner	☐ Blood Transfusion	☐ Bronchitis	☐ Liver Disease
☐ Low Blood Pressure	☐ Mental Disorders	☐ Migraines	☐ Tuberculosis
☐ Tumors	☐ Cancer	☐ Chronic Pain	☐ Diabetes
☐ Glaucoma	☐ Head Injuries	☐ Heart Attack	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ HIV-AIDS
☐ Kidney Disease	☐ Ulcers	☐ Mitral Valve Prolapse	☐ Nervous Disorders
☐ Neurological Disorders	☐ Osteoporosis	☐ Pacemaker	☐ Pregnancy
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Sleep Disorder	☐ Sexually Transmitted Disease	
☐ Stomach Problems	☐ Stroke	☐ Thyroid Problems	☐ Tobacco/Alcohol Use

Indicate which of the following allergies you have or have had. Please check those that apply:

☐ Amoxicillin	☐ Aspirin	☐ Codeine	☐ Iodine
☐ Penicillin	☐ Sedatives	☐ Iodine	☐ Latex
☐ Sulfa	☐ Local Anesthetics		

Habits

☐ Thumb ☐ Tongue ☐ Lip Sucker ☐ Airways Problems Other: _____

Do you smoke?

☐ Yes ☐ No If yes: ☐ Occasionally ☐ Moderate ☐ Heavy

Do you have any disease, condition, or problem not listed above that you think we should know about?

☐ Yes ☐ No If yes, please explain: _____

Indicate medications you are currently taking. Please check those that apply:

☐ Blood thinners ☐ Painkillers ☐ Antibiotics ☐ Chemotherapy

☐ Others

List all medications you are currently taking (prescription and non-prescription): _____

_____

DENTIST 4
1711 Hammondville Rd. Pompano Beach, Fl 33069 / 2331 N State Rd 7, Ste 109-110, Lauderhill, Fl 33313
Tel: 954-972-6066 / 954-486-6989 / E-Mail: contact@sunshinedentalcenter.us