Dentist 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)

Whom may we thank for referring you to our practice?

☐ Current Patient ☐ Dental Office ☐ Internet Search ☐ Insurance ☐ Other

Name of the person or office referring you to our practice:

RESPONSIBLE PARTY INFORMATION

This only needs to be filled out if the insurance subscriber is other than the patient, or you are the parent or guardian of the patient.

The following is for: ☐ The patient's spouse ☐ The person responsible for payment ☐ Not applicable

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)

MEDICAL INFORMATION:

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever had any complications following dental treatment?

☐ Yes ☐ No If yes, please explain: _____

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

☐ Yes ☐ No If yes, please explain: _____

Are you under the care of a physician?

☐ Yes ☐ No Name of Physician: _____ Phone: _____ Treatment: _____

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

☐ Yes ☐ No

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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

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DENTAL INFORMATION:

Is the main reason of your visit pain or an emergency?

☐ Yes ☐ No If yes, please explain: _____

Have you notice any gum bleeding?

☐ Yes ☐ No If yes, please explain: _____

Have you noticed or felt any bad breath?

☐ Yes ☐ No If yes, please explain: _____

Are you satisfied with your biting or chewing ability?

☐ Yes ☐ No

Are you satisfied now with the appearance of your teeth?

☐ Yes ☐ No If no, please explain: _____

Do you want to keep your teeth?

☐ Yes ☐ No If no, please explain: _____

When was your last cleaning? _____

How often do you brush your teeth?

☐ Once a Day ☐ Twice a Day ☐ Three Times a Day

How often do you floss?

☐ Once a Day ☐ Twice a Day ☐ Three Times a Day

Check all that apply:

☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Had trouble getting numb
☐ Had/have orthodontic treatment
☐ Food gets trapped between any teeth
☐ Have sensitive teeth
☐ Clench or grind your teeth
☐ Have difficulty chewing

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

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you agree that you received and understand our Notice of Privacy Practices. The Notice of Privacy Practices explains the uses and disclosures of my protected health information that may be made by **Sunshine Dental Center.**

We reserve the right to modify the terms of our Notice of Privacy Practices. If changes occur, we will provide you with a revised Notice of Privacy Practices upon request.

Please print your name

Please sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your relationship.

Thank you, and if you have any questions about this form or the attached Notice, please contact our office by calling us at 954-972-6066 or by going to Sunshine Dental Center at 1711 Hammondville Rd, Pompano Beach, Fl 33069.

OFFICE USE ONLY

I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign

Please describe:

Signature of Staff Member