



Vero Beach

Dental Care

PATIENT INFORMATION

Date _____

Thank you for choosing VERO BEACH DENTAL CARE for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ Social Security # _____
First Middle Initial Last

Nickname: _____ Email address: _____

Address _____ City _____

State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Do you prefer to receive calls at: Home Work Cell

Sex: Female Male Date of Birth _____ Age _____

Married Widowed Single Minor Separated Divorced

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ ST _____ Zip _____

Spouse or Parent's name _____ Employer _____ Phone (____) _____

How did you hear about our practice? _____ If radio, what station? _____

Person to contact in case of emergency _____ Phone(____) _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to patient _____ Phone # (____) _____

Address _____ City _____ State _____ Zip _____

Name of Employer _____ Work Phone (____) _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone (____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITIONAL INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone (____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

DENTAL HISTORY

Please check any of the following conditions that apply to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sores or growths in mouth |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sensitivity when biting |

Are you having pain or discomfort at this time? _____
 Are you nervous about dental treatment? _____
 Have you had a previous bad dental experience? _____

MEDICAL HISTORY

Physician _____ Physicians Phone # _____

Please list all medications you are taking _____

(WOMEN) Are you pregnant? _____ Nursing _____ Taking Birth Control Pills _____

Check if you have had any of the following:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Congenital Heart Lesion	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Cough Up Blood	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Diabetes	<input type="checkbox"/> TMJ (Jaw Pain)	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Swelling of Feet & Ankles
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Bleeding Abnormally	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Other	

ALLERGIES: _____

Are you currently or have you ever taken any of these medications for OSTEOPOROSIS, PAGETS DISEASE, OR CANCER-RELATED ILLNESSES? Coumadin Levoxyl Warfarin
 Synthroid Actonel Aredia Bonetos Boniva Didronel Fosamax
 Ostac Skelid Zometa.

CERTIFICATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of patient or responsible party

CONSENT

The undersigned hereby authorizes Dr. Clay to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Clay to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Clay to perform any and all forms of treatment, medication and therapy that may be indicated in connection with **(Name of patient)** _____ and further authorize and consent that Dr. Clay choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1 1/2 % finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ **Date** _____ **Witness** _____

Parent or Responsible Party _____ **Relationship to Patient** _____