



Roger D. Clay, DDS

Morgan Clay, BA, MS, DMD

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 you. We DO NOT participate with any Insurance Company; therefore, this office is considered out-of-network.

DATE: _____

PATIENT INFORMATION

Name _____ Social Security # _____
First MI Last

Preferred Name: _____ Email Address: _____

Address: _____

Date of Birth: _____ Sex: Female Male Marital Status: M W S D

Home Phone: _____ Cell Phone _____ Work Phone _____

Preferred Contact Method for Confirming Appointments (Please check): Home Work Cell Text

Do you give consent for communicating via text messaging with the cell phone number? _____

Patient Employer or School _____ Occupation: _____

Employer or School Address _____

Spouse or Parent's Name _____ Employer _____

Have any other family members been seen in this office? _____

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 pt. _____

Address _____ Phone # _____

Name of Employer _____ Phone # _____

DENTAL INSURANCE INFORMATION *The financial responsibility for dental services lies solely with the patient. Dental insurance is a contract between the patient and their insurance company. Our involvement is only to submit a claim as a courtesy to help our patient. It is ultimately up to the patient to be fully aware and up-to-date on the status of their insurance at any particular time and to pay for services rendered regardless of insurance coverage. We do not participate with any dental insurance companies. Our office is considered "out-of-network." After 60 days, all unpaid claims become the responsibility of the patient.*

Name of Insured _____ Relationship to patient _____

Date of Birth _____ Social Security # _____

Name of Employer _____ Phone # _____

Insurance Company _____ Member ID # _____ Group # _____

Insurance Company Address _____

Date of Birth _____ Social Security # _____ Name of
 Employer _____ Phone # _____ Insurance
 Company _____ Member ID # _____ Group # _____

DENTAL HISTORY:

Approximate date of last full mouth x-rays: _____ where could these x-rays be obtained? _____

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? _____
 Are you happy with the appearance of your teeth? _____ If no, what would you like to change? _____

MEDICAL HISTORY

Physician _____ Have you been told you need to pre-medicate before dental treatment? _____

Please list (or give us a copy) of all medications you are currently taking: _____

Do we have permission to download your medication list from Surescript? Yes No

WOMEN ONLY - Are you Pregnant? _____ Nursing? _____ Taking Birth Control Pills? _____

Check if you have had any of the following:

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

Please list any known ALLERGIES, Date of reaction, and Description of reaction: _____

Are you currently or have you **EVER** taken any of these medications for OSTEOPOROSIS, PAGETS DISEASE, OR CANCER-RELATED ILLNESSES?

<input type="checkbox"/> Coumadin	<input type="checkbox"/> Levoxyl	<input type="checkbox"/> Warfarin	<input type="checkbox"/> Synthroid	<input type="checkbox"/> Actonel	<input type="checkbox"/> Aredia	<input type="checkbox"/> Bonifos
<input type="checkbox"/> Boniva	<input type="checkbox"/> Didronel	<input type="checkbox"/> Fosamax	<input type="checkbox"/> Ostac	<input type="checkbox"/> Skelid	<input type="checkbox"/> Zometa	<input type="checkbox"/> Prolia

If YES, when was your last dose? _____ Reason for dose _____

CERTIFICATION

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

CONSENT

The undersigned hereby authorizes Dr. Roger Clay or Dr. Morgan Clay to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Roger Clay or Dr. Morgan Clay to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Roger Clay or Dr. Morgan 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. Roger Clay or Dr. Morgan 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 ½ % finance charge (18% annually) will be added to any balance over 90 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. **By signing this agreement, I acknowledge that I have read the above conditions of treatment and payment and agree to their content.**

PATIENT _____ **DATE** _____ **WITNESS** _____

PARENT OR RESPONSIBLE PARTY _____ **RELATIONSHIP TO PT.** _____