Vero Beach
Dental Care

Roger D. Clay, DDS

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

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.***

Name of Insured _____ **Relationship to patient**_____

Date of Birth _____ **Social Security #**_____

Name of Employer_____ Phone #_____

Insurance Company_____ **Member ID #**_____ **Group #** _____

Insurance Company Address_____

Do you have a Secondary DENTAL INSURANCE?

Name of Insured _____ Relationship to patient_____

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:

__Food collection between teeth	__Loose teeth or broken fillings	__Sores or growths in mouth
__Bad Breath	__Grinding teeth	__Sensitivity to heat
__Bleeding gums	__Periodontal treatment	__Sensitivity to sweets
__Clicking or popping jaw	__Sensitivity to cold	__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_____

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

_____

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

Check if you have had any of the following:

__Alzheimer	__Dementia			
__Aids	__Congenital Heart Lesion	__Hepatitis	__Rheumatic Fever	__Scarlet Fever
__Anemia	__Cortisone Treatments	__Hernia Repair	__Shortness of Breath	__Stroke
__Arthritis, Rheumatism	__Cough, Persistent	__High Blood Pressure	__Skin Rash	__Thyroid Problems
__Artificial Heart Valves	__Cough up Blood	__HIV Positive	__Tobacco Habit	__Tonsillitis
__Artificial Joints	__Diabetes	__TMJ (Jaw Pain)	__Tuberculosis	__Ulcer
__Back Problems	__Fainting	__Liver Disease	__Venereal Disease	__Bleeding Abnormally
__Cancer	__Heart Murmur	__Pacemaker	__Chemical Dependency	__Heart Problems
__Glaucoma	__Mitral Valve Prolapse	__Blood Disease	__Headaches	__Nervous Problems
__Psychiatric Care	__Chemotherapy	__Hemophilia	__Radiation Treatment	__Circulatory Problems
__Respiratory Disease	__Surgery (What type?) _____	__Other	__Chronic Sinus Problems	

Any known 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	__Bonefos
__Boniva	__Didronel	__Fosamax	__Ostac	__Skelid	__Zometa	__Prolia

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. Clay if I, or my minor child, ever have a change in health.*

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 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.*

PATIENT_____ **DATE** _____ **WITNESS**_____

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