Vero Beach Dental Care

Morgan Clay Morrison 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.

PATIENT INFORMATION:

Name: _____ Social Security #: _____

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 listed? _____

Patient Employer or School: _____ Occupation: _____

Employer or School Address: _____

Spouse or Parent's name: _____ Employer: _____

Have any other family members been seen in our office? _____ How did you hear about our practice? _____

Person to contact in case of emergency? _____ Phone #: _____

RESPONSIBLE PARTY: Name of person responsible for this account: _____

Relationship to patient: _____ Phone #: _____

Address: _____

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 patients. 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 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: _____

DENTAL HISTORY:

___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

Approximate date of last full mouth x-rays:_____ Where can these x-rays be obtained? _____

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

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

Are you nervous about dental treatment _____ Are you happy with the appearance of your teeth? _____

If not, what would you like to change? _____

MEDICAL HISTORY:

Physician: _____ Pharmacy: _____

Have you been told that 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 of the following:

__Alzheimer	__Dementia	__Hepatitis	__Rheumatic Fever	__Stroke
__Aids	__Congenital Heart Lesion	__Hernia Repair	__Shortness of Breath	__Thyroid Problems
__Anemia	__Cortisone Treatment	__ High Blood pressure	__Skin Rash	__Tonsilitis
__Arthritis, Rheumatism	__Cough, persistent	__HIV Positive	__Tobacco Habit	__Ulcer
__Artificial Heart Valve	__Cough up blood	__TMJ (Jaw Pain)	__Tuberculosis	__Abnormal Bleeding
__Artificial Joints	__ Diabetes	__Liver Disease	__Venereal Disease	__Heart Problems
__Back Problems	__Fainting	__Pacemaker	__Chemical Dependency	__Nervous Problems
__Cancer	__Heart Murmur	__Blood disease	__Headaches	__Circulatory Problems
__Glaucoma	__Mitral Valve Prolapse	__Hemophilia	__Radiation Treatment	__Other:
__Psychiatric Care	__Chemotherapy	__Blood Thinners	__Chronic Sinus Problems	
__Respiratory Disease	__Surgery (type)	__Restless Leg Syndrome	__Scarlet Fever	

Please list any knows 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 CANCAER RELATED ILLNESSES?

__Coumadin	__Levoxyl	__Warfarin	__Synthroid	__Actonel	__Aredia	__Bonefos
__Boniva	__Didronel	__Fosamax	__Ostac	__Skelid	__Zometa	__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. Morgan Clay Morrison if I, or my minor child, ever have a change in health.

CONSENT

The undersigned hereby authorizes Dr. Morgan Clay Morrison to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Morgan Clay Morrison to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Morgan Clay Morrison to perform any and all forms of dental treatment, medication and therapy that may be in connection with (Name of patient) _____ and further authorize and consent that Dr. Morgan Clay Morrison choose and employ such assistance as deemed fit. I also understand that 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 a 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 _____

PATIENT OR RESPONSIBLE PARTY _____ RELATIONSHIP TO PT. _____

INSURANCE ACKNOWLEDGEMENT

I _____ realize that Vero Beach Dental Care is an out of network provider and that I am totally responsible for what my insurance does not pay. As a courtesy, Vero Beach Dental Care has agreed to submit treatment that I have received in this office to my insurance company.

SIGNATURE _____ DATE _____