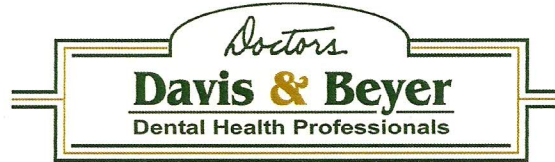


1218 E. Venice Ave.
Venice, FL 34285
(941) 488-1075
Fax: (941) 484-6277



www.venicedentist.com
Email: info@venicedentist.com

PATIENT INFORMATION

Date: _____

Name: _____ I prefer to be called: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work: _____ Cell: _____

Out of town Address: _____ City: _____ State: _____ ZIP: _____

Email Address: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Place of Birth: _____

Sex: M F Marital Status: Married Single Widowed Divorced Student

Place of Employment: _____ Occupation: _____

Spouse or Parent's Name: _____ Employer: _____ Phone: _____

Has any member of your family ever been treated in our office? Yes No

Whom may we thank for referring you? _____

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

Name: _____ Tel #: _____

Address: _____ City: _____ St _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____

Insurance Co: _____

ID/SNN Number: _____

Group #: _____

SECONDARY DENTAL INSURANCE INFORMATION

Insured's Name: _____

Insurance Co: _____

ID/SNN Number: _____

Group #: _____

METHOD OF PAYMENT: I prefer to pay by: Check Cash Credit Card

FINANCE CHARGE: If I do not pay the entire New Balance within 25 days of the statement date a FINANCE CHARGE will be added to the account for the billing period. The FINANCE CHARGE will be periodic rate of 1% per month which is an ANNUAL PERCENTAGE RATE OF 12%. In case of default of payment I promise to pay any legal interest on the balance due, together with Any collection costs and reasonable attorney fees incurred to effect collection of this account.

APPOINTMENTS: Please be advised 24 hours notice must be given if a cancellation is absolutely necessary, otherwise you will be charged a cancellation fee.

AUTHORIZATION: I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer medications, perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I certify that the above information & medical history is true and correct to the best of my knowledge.

Patient Signature: _____

Please Continue Filling Out Your Information On The Other Side Of This Form

DENTAL INFORMATION

What is the reason for your dental visit today? _____

Would you like to improve your smile? Yes No

If So, what is the first condition you would like doctor to address: _____

	YES	NO	NOTES
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY	<input type="checkbox"/>	<input type="checkbox"/>	
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	

Date of your last dental exam: _____

Previous Dentist: _____

What was done at that time? _____

Date of last dental x-rays: _____

