Missouri Gardens Dental
15 N Missouri Ave Clearwater, FL 33755
Phone (727) 461-4832 Fax (727)461-4835
Dr Anisha Patel D.M.D
Dr. Thuy Vazquez D.D.S

Patient Registration

Last Name: _________________________ First Name: _____________________________ DOB: ________________________________

Sex: **M or F** Social Security #: _____________________________ Please Circle One: Single Married Separated Widow

Mailing Address: ____ City: _________ State: ____________ Zip Code: ______________

Email: _____________________________________ Home Phone: (__) __________________Cell Phone: (___) ________________________

Driver's License: ____ Employer: ____

Work Phone: ____________________________ Occupation: ____________________________ Are you a full-time student? Y or N

If patient is minor: Mother's DOB: ______________________________________ Father's DOB: ____________________________________

Name of Parent: ___________________________________Parent's Soc. Sec #: ____

Parent Employer: ____ Parent Phone: (____) _________________________________

Person Responsible for Account: ______________________________ Relationship: ____

Emergency Contact: _________________________ Relationship: ______________________________ Phone #: ________________________

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name: ____ Relationship: ____

Reason for today's visit? ____

How did you hear about us?

☐In-home Mailer ☐Social Media ☐Insurance ☐Practice ☐Website ☐Internet ☐Family/Friend/Coworker

Other: ___________________________________ *Who can we thank for your visit?* ____

Dental Insurance Information (Primary Carrier)	**Dental Insurance Information Secondary Coverage**
Insured's Name: _____________________________________	Insured's Name: ____
Insured's Employer: _________________________________	Insured's Employer____
Insured's DOB: ______________________________________	Insured's DOB: ____
Insured's Co: _________________________________	Insured's Co: ____
Insured's Co Address: ____________________________	Insured's Co Address: ____
Insured's Phone #: _____________________________	Insured's Phone #: ____
Group #: ______________________________________	Group #: ____
Local #: ______________________________________	Local #: ____

Dental History On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where do you want your dental health to be?	1	2	3	4	5	6	7	8	9	10

What would you like to change about your smile?

☐Color ☐Bite ☐Chipped Teeth ☐Spaces ☐Crowding ☐Smile Makeover ☐Missing Teeth ☐Whiter Teeth

Please share the following dates:

Your last cleaning: _________/________ Your last oral cancer screening: _________/________ Your last complete X-rays: _________/_________

- What is the most important thing to you about your future smile and dental health? ____
- What is the most important thing to you about your dental visit today? ____
- Why did you leave your previous dentist? ____
- Name of your previous dentist? ____

Dental History Cont. Please mark any of the following conditions that apply to you

Appearance
☐Discolored teeth
☐Worn teeth
☐Misshaped teeth
☐Crooked teeth
☐Spaces
☐Overbite
☐Flat teeth

Pain/Discomfort
☐Sensitivity (hot,cold,sweet)
☐Pressure
☐Broken teeth/fillings
☐Worn Teeth
☐Dry mouth

Function
☐Grinding/Clenching
☐Headaches
☐Jaw Joint (TMJ) pain
☐Jaw Joint (TMJ) clicking/popping
☐Bad bite
☐Speech Impediments
☐Mouth Breathing
☐Sore muscles (neck, shoulders)
☐Difficulty Opening or Closing
☐Difficulty chewing on either side

Periodontal (Gum Health)
☐Bleeding, Swollen, Irritated gums
☐Bad breath
☐Loose tipped, shifting teeth
☐Previous perio/gum disease

Habits
☐Thumb sucking
☐Nail-biting
☐Cheek/Lip biting
☐Chewing on ice/foreign objection

Sleep Pattern or Conditions
☐Sleep Apnea
☐Snoring
☐Daytime Drowsiness
☐Bed wetting (for children)

Social
☐Tobacco
☐How much? ____ How long? ____
☐Alcohol Frequency___________
☐Drugs Frequency_____________

Previous Comfort Options
☐Nitrous Oxide
☐Oral Sedation (Pill)
☐IV Sedation

Please list family history of any conditions marked:
____
____
____
____
____
____
____
____
____
____
____

Medical History Please mark to your response to indicate if you have or have had any of the following

Cardiovascular:
☐Angina (chest pain)
☐Artificial Heart Valve
☐Heart Conditions
☐Heart Surgery
☐High Blood Pressure
☐Low Blood Pressure
☐Mitral Valve Prolapse
☐Pacemaker
☐Rheumatic Fever
☐Scarlet Fever
☐Stroke

Cancer-Type: _________
☐Chemotherapy
☐Radiation

Endocrinology:
☐Diabetes
☐Hepatitis A/B/C
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Thyroid Disease

Gastrointestinal:
☐GERD
☐Ulcers (Stomach)

Viral Infections:
☐AIDS
☐HIV Positive
☐HPV

Respiratory:
☐Asthma
☐Emphysema
☐Respiratory Problems
☐Sinus Problems
☐Sleep Apnea
☐Tuberculosis

Hematologic/Lymphatic:
☐Anemia
☐Blood Disorders
☐Bruise Easily
☐Excessive Bleeding
☐Pregnant
☐Nursing

Musculoskeletal:
☐Arthritis
☐Artificial Joint
☐Jaw Joint Pain
☐Rheumatoid Arthritis

Neurological:
☐Anxiety
☐Depression
☐Dizziness
☐Drug/Alcohol
☐Fainting
☐Seizures
☐Psychiatric Illness

Women:
☐Currently Pregnant
☐Nursing

Medical Allergies:
☐Antibiotics
(Penicillin/Amoxicillin/Clindamycin)
☐Opioids
(Percocet, Oxycodone, Tylenol 3)
☐Latex
☐Local Anesthetics
☐NSAIDs

Other Allergies:
☐______________________

Additional Comments:
☐______________________
____

Are you under the care of a physician? **Y or N**. If yes, please explain.
____

Physician Name: __________________________ Address: ____ Phone: ______________________

Have you had a serious illness, operation, or hospitalization in the past 5 years? **Y or N**, if yes please explain?
____
____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? **Y or N**. If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements.
____
____
____
____

Have you ever in the past, or are you currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If so, please list all medications:
____
____

Have you ever had surgery? If so, what type:
____
____
____

Consent:

The undersigned hereby authorizes Doctors to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any forms of treatment, medication, and therapy that may be indicated. I understand the use of anesthetic agents embodies a certain risk. I have read, understood, and agreed to the above terms and conditions.

____________________________ ____________________ ____________ ________________________

Signature of Patient/Legal guardian Print Name Date Dentist Signature

Financial policy

Thank you for choosing our office as your Dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time services provided. Our office excepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options.☐

Please note: returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.

Do you have insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

- As a courtesy to you we will help you process all your insurance claims. Please understand we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form and structure insurance company to make payment directly to our office.

- We ask that you pay the deductible and copayment, which is the estimated amount, not covered by your insurance company, buy cash, check, credit card or patient financing at the time we provide the service to you.

- We will cooperate fully with the regulations and request of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental healthcare needs and welcome any questions you may have concerning your cared or our financial policy

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. 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 unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

____ ___________________

Patient Signature (Parent if child) Date

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, ____, have received a copy of this office's Notice of Privacy Practices.

____

Patient Name (Printed)

____

Signature

____

Date

Authorization To Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, ____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

______________________________________	______________________________________
Name *(Printed)*	*Relationship*
______________________________________	______________________________________
Name *(Printed)*	*Relationship*
______________________________________	______________________________________
Name *(Printed)*	*Relationship*

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

☐Communications barriers prohibited obtaining the acknowledgement

☐An emergency situation prevented us from obtaining acknowledgment

☐Other *(Please Specify)*

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