Welcome

ABOUT YOU

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #: (____)_____ Cell #: (____)_____ Work Phone #: (____)_____ Ext: ____ Driver License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____)_____ Home Phone #: (____)_____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (____)_____ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: ____ Drivers License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: _____ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? _____

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you still have wisdom teeth? ❑ Yes ❑ No

If yes, why? _____

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen? _____

_____

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No Date of last visit: _____

Physician's Name: _____

Address: _____ Phone #: (___) _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❑ Yes ❑ No

Have you ever taken Fosamax, or any other Bisphosphonate? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions: _____

_____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Thinners	Y N Digitalis/Heart Medication	Y N Recreational Drugs
Y N Antibiotics	Y N Blood Pressure Medication	Y N Insulin/Diabetes Drugs	Y N Steroids/Cortisone
Y N Antihistamines	Y N Cold Remedies	Y N Nitroglycerin	Y N Thyroid Medicine
Y N Aspirin			Y N Tranquilizers

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ❑ Yes ❑ No If yes, please list each one: _____

_____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Osteoporosis/Paget's Disease	Y N Steroid Therapy
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Psychiatric Treatment	Y N Tonsillitis
Y N Cancer	Y N Fever Blisters	Y N HIV$^+$/AIDS	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for Any Reason	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Scarlet Fever	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

_____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature Date

Patient Financial Agreement

Softouch Dental
Lake Mary, FL

I understand that full payment is due at the time of service for me and any of my dependants

I understand that it is my sole responsibility to confirm which treatments or procedures are covered by my insurance (including but not limited to any applicable exclusions, deductibles, and annual or lifetime maximums).

I understand that as a courtesy, Softouch Dental will fill out any claim forms provided for me to file with my insurance company. I am required to pay in full, before treatment is performed, for services performed today.

I understand that if I discontinue treatment for a requested procedure, including but not limited to partials, dentures, crowns, bridgework and surgical preparatory work. I remain responsible for paying all lab related costs for material and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund to which I may be entitled for discounted treatment.

I understand that all account balances over 30 days will incur an interest charge at the maximum legal rate allowed.

I understand that I will be charged the maximum service charge allowed by law for any dishonored check, electronic authorization or any debit sent or provided to Softouch Dental for payment.

I understand that I must timely inform Softouch Dental, in writing, of any concerns, questions, or disputes I may have concerning my treatment or changes.

I understand that if I fail to pay my account in a timely manner, Softouch Dental may report my account to credit rating bureaus or a collection agency and/or take legal action against me for full payment including but not limited to all related reasonable attorney's fees, collection and/or court costs.

I understand that unless patient records are sent directly to another provider, the charge for copies of x-rays is $20.00 and treatment information is $5.00 or the maximum allowed by law. These fees are subject to change without notice.

I understand that it is my responsibility to immediately notify Softouch Dental of any changes to my address, phone number, work contact information, work status, insurance changes, etc.

I have read thoroughly and understand and agree to the above terms.

_____ _____

Signature of Patient or Guardian Date

General Dentistry Informed Consent

Softouch Dental
Lake Mary, Florida

Please initial below.

_____ **Treatment to be Rendered**

I understand that I am having the following treatment performed.
-Exam, X-rays, Other _____.

_____ **Drugs and Medication**

I understand that antibiotics, analgesics and other medications that I may be prescribed can cause allergic reactions, including but not limited to redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock death, a severe allergic reaction. I also understand that these medications interfere with the effectiveness of contraceptives.

_____ **Changes in Treatment Plan**

I understand that during my treatment it may be necessary to change or add procedures that were not discovered during my examination. For example, if complications arise after a routine restorative procedure, root canal therapy may be necessary. I give my permission to the dentist to make any changes and/or additions as necessary.

_____ _____

Patient or Guardian Signature Date

Cancellation/ Broken Appointment Policy

Softouch Dental
Lake Mary, FL

In order to give all our patient an opportunity to be seen in a timely manner, please read the following cancellation policy.

Cancellation of any appointment is required **48 hours** prior to the appointment time.

Upon the first missed appointment you will be given a warning and required to prepay for the next appointment for any treatment.

If you miss the prepaid appointment, you will forfeit your payment and be dismissed from the practice.

I understand the cancellation policy stated above.

*Signature*_____ *Date*_____

SofTouch
DENTAL
Center For Aesthetic Dentistry

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.

Print Name: _____

Sign: _____

Date: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you 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.

_____
{Please Print Name} Relationship

_____
{Please Print Name} Relationship

_____
{Please Print Name} Relationship

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