Coastal Smiles Marco
Tyler Frey DMD PA
Dr. Tyler Frey, DMD

1770 San Marco Rd #202
Marco Island, FL 34145
(239) 394-3200

Patient Registration

Date _____

Patient Name _____
(Last Name) (First Name)

Is this your legal name _____ If not, what is your legal name _____

Date of Birth _____ Age _____

Social Security Number _____

Home Phone _____Cell Phone _____

Email_____

Address _____ City/Zip _____

Other family members seen here: _____

How did you hear about us? (Please circle one if applicable)

Walk-in

Google

Newspaper

Word of Mouth Referred by: _____

Emergency Contact

Name _____

Relationship _____

Phone Number _____

Patient/Guardian signature:_____

Date:_____

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Fees & Payments

I understand all payments are due at the time of service for any services rendered on my behalf or my dependents behalf. For your convenience, we accept all credit cards, including Care Credit financing. If credit cards are not your method of payment, we do take personal checks with proper identification as well as cash. The parties hereto agree that in the event the office of Coastal Smiles Marco (Tyler Frey DMD PA) has to place the indebtedness incurred by the patient for the services rendered into the hands of an attorney for collection then the office of Coastal Smiles Marco (Tyler Frey DMD PA) shall be entitled to recover from the patient any attorney's fees and costs/expenses incurred for the collection whether the attorney's fees and costs/expenses were prior to or after filing suit for collection.

Insurance Policy

I understand that the dental office of Coastal Smiles Marco (Tyler Frey DMD PA) does not desire to see any patients with any form of third-party payment. That includes any form of dental insurance or discount plans. Our policy allows us to lower our fees for the uninsured. We are dedicated to the uninsured and the uninsured only. I acknowledge that I do not have any form of third-party insurance and I will not request the office of Coastal Smiles Marco (Tyler Frey DMD PA) to provide any assistance with insurance compensation.

Patient/Guardian signature:_____

Date:_____

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Consent For Treatment

I authorize dentist(s) of **Coastal Smiles Marco (Tyler Frey DMD PA)** and/or such associates or assistants they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore and tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient/Guardian signature:_____

Date:_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1966, (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessments and doctor certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above and obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment and payment of health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree, then you are bound to abide by such restrictions.

Patient/Guardian signature:_____

Date:_____

Medical History

Coastal Smiles

Patient's Name: _____ Date:_____

Although Dental Personnel Primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking can all have an effect on your oral health. Please do your best to answer the following questions to the best of your ability.

General Questions:	Y / N	*If Yes, Please Specify:*
Are you Under a Physician's Care now?	Y / N	
Have you ever been hospitalized or had a major operation?	Y / N	
Have you ever had a serious head or neck injury?	Y / N	
Are you taking any medications, pills, drugs? Please specify the medication name.	Y / N	
Are you taking any blood thinners? (Eliquis, Aspirin, Pradaxa, Savaysa, Lixian, Xarelto.. etc)	Y / N	
Do you take, or have you ever taken, Phen-Fen or Redux?	Y / N	
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Y / N	
Are you on a special diet? *Please specify.*	Y / N	
Do you use controlled substances? *Please specify.*	Y / N	

Women: Are you…

☐ Pregnant / Trying to get pregnant	☐ Nursing?	☐ Oral Contraceptives?

Are you Allergic to any of the following?

☐ Aspirin ☐ Metal	☐ Penicillin ☐ Latex	☐ Codeine ☐ Sulfa Drugs
☐ Other? *Please Specify:*		

Please Continue to second page:

Medical History

Coastal Smiles

Do you have, or have you had, any of the following?

Check if Yes, leave blank if No.

- ☐ AIDS/ HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/ gout
- ☐ Artificial Heart Valve: *Date Placed:* _____
- ☐ Artificial Joint: *Date Placed:*_____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer: Current /Prev
- ☐ Chemotherapy: Current/Prev
- ☐ Chest Pains
- ☐ Cold Sores/ Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/ Growths
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/ Disease
- ☐ Hemophilia
- ☐ Hepatitis A, B or C
- ☐ Scarlet Fever
- ☐ Spina Bifida
- ☐ Stomach / Intestinal Disease
- ☐ Stroke
- ☐ Ulcers
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives/ Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung DIsease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in jaw joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent WeightLoss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above?

If yes:

Any Comments or anything you feel would make your visit with us more comfortable?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X_____ Date: _____