

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

Mail

Word of Mouth Referred by: _____

Emergency Contact

Name _____

Relationship _____

Phone Number _____

Patient/Guardian signature: _____

Date: _____

Dental Insurance Information

Employer _____

SSN _____

Insurance Company Name _____

Insurance Address _____

Name of Insured _____

Date of Birth of Insured _____

Member ID # _____

Social Security of Insured _____

Insurance Group # _____

Insurance Phone Number _____

Relationship to Patient _____

***I hereby authorize the release of any information necessary to process my insurance claim. I further authorize payment to the dentist insurance benefits otherwise payable to me. A copy of this signature is as valid as the original.*

***Please note we do not accept the responsibility for collecting your insurance claim beyond 60 days or negotiating a settlement on a disputed insurance claim. You are responsible directly to us for a payment of your account if insurance has not been paid within 60 days. You are also responsible for any and all collection fees and/or attorney fees.*

Patient/Guardian signature: _____

Date: _____

Insurance

Your dental insurance may cover some, but not all, of our treatment. Most plans include copays, deductibles, a percentage that they cover and a percentage that you will need to pay. This will be paid the day of your visit. It is your responsibility to provide us with the correct dental insurance information. We do not file any secondary insurance plans. Please be aware that if your account is 30 days past due, regardless of insurance or being a provider, you are responsible for your outstanding balance. If the account becomes 60 days past due, you will be assessed a \$5 monthly service charge and it will be turned over to an outside collection agency. If this occurs, you will be responsible for all costs from the collection agency and/or attorneys.

Fees & Payments

All payments, co-pays, and deductibles are due the day of the visit for all services rendered. For your convenience, we accept all credit cards, including Care Credit. If credit cards are not your method of payment, we do take personal checks with proper identification as well as cash.

Patient/Guardian signature: _____

Date: _____

Consent For Treatment

I authorize dentist(s) of **Coastal Smiles Naples (Naples General Dentistry LLC)** 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.

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Patient/Guardian signature: _____

Date: _____

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? <i>Please specify.</i>	Y / N	
Do you use controlled substances? <i>Please specify.</i>	Y / N	

Women: Are you...

<input type="checkbox"/> Pregnant / Trying to get pregnant	<input type="checkbox"/> Nursing?	<input type="checkbox"/> Oral Contraceptives?
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Are you Allergic to any of the following?

<input type="checkbox"/> Aspirin <input type="checkbox"/> Metal	<input type="checkbox"/> Penicillin <input type="checkbox"/> Latex	<input type="checkbox"/> Codeine <input type="checkbox"/> Sulfa Drugs
<input type="checkbox"/> Other? <i>Please Specify:</i>		

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.

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