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Confidential Dental and Medical History

Patient's Name: _____ Age:_____ Date of Birth_____
Address:_____ _____
City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Email:_____
Best Contact Method (Circle one) E-mail / Cell / Text / Home
Best Time to Reach You:_____
SS#:_____ Sex:_____
Marital Status: Single / Married / Widowed / Divorced
Employer:_____ Employer Address:_____
Spouse's Name:_____ Spouse's Phone:_____
Emergency Contact:_____ Relation:_____
Emergency Contact Phone:_____
Do you have Dental Insurance? (Circle one) YES // NO
Insurance Carrier's Name:_____
Group #:_____ Insurance Phone:_____
Subscriber's Name:_____ Subscriber's SS#_____
Subscriber's ID:_____ Relation to Patient:_____
Subscriber's DOB:_____
Employer/Co. Name:_____Phone:_____
Employer/Co Address:_____
Insurance Carrier Address:_____
HOW DID YOU HEAR ABOUT US?_____

Would you like to receive appointment reminders via text message?_____

MEDICAL POLICY
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IN ORDER FOR US TO PROVIDE YOU WITH THE SAFEST AND BEST POSSIBLE CARE, PLEASE COMPLETE THESE MEDICAL AND DENTAL HISTORY FORMS.

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.

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Are you taking any prescription drugs, over the counter medications, or herbal supplements during the last 6 months? **YES /NO**
PLEASE LIST:_____
_____
_____

Are you allergic to (i.e itching, rash, swelling of hands, feet, or eyes) or made sick by any medication? **YES / NO**
PLEASE LIST:_____

Do you have any heart conditions past OR present? **YES/NO**

If YES – Circle the following that pertains to you:

Heart attack / Heart surgery / Pacemaker / Stroke / Artificial Heart Valve
List date(s): _____

Have you had any artificial joint replacements? **YES/ NO**
Date(s):_____

Have you had ANY eye surgeries (including cataracts) in the past 30 days? **YES / NO**
Date(s):_____

Do you have any eye surgeries (including cataracts) scheduled in the next 30 days? **YES / NO** Date:_____

Have you been diagnosed with cancer? If yes, please list type(s) and dates:_____
If yes, did you undergo Chemo/Radiation?_____

Have you ever taken Immunosuppressant drugs like Methotrexate or certain steroids for conditions such as Lupus or Rheumatoid Arthritis? **YES / NO**
Have you ever taken, or are you currently taking any drugs for Osteoporosis? **YES / NO**

Use of alcohol: **YES / NO** – *Daily / Weekly / Monthly* (Circle One)
Recreational Drug Use: **YES/ NO**
Do you use Tobacco? **YES / NO** Vape: **YES / NO**
What type and much per day? _____

FEMALE PATIENTS:
Are you pregnant? **YES / NO**
Use Birth Control? **YES / NO**
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Planning to become pregnant? **YES / NO**

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Patient Name: _____

Circle any of the following which you have at the present or have had in the past:

High Blood Pressure - Low Blood Pressure - Kidney Disease

Thyroid/Gland Problems - Liver Disease - Hepatitis/Jaundice

Diabetes - Asthma/Bronchitis – Emphysema/COPD

Allergies/Sinus Problems – Seizures/Epilepsy – Arthritis

HIV/AIDS – Sexually Transmitted Diseases – Anemia

Do you bleed excessively during dental treatment or surgery? **YES / NO**
Sleep Apnea? **YES / NO**

Please read the following carefully: To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself, or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetic or pre-medications which may be deemed advisable.

_____

Signature: Date:

Ocean Drive
DENTISTRY

DENTAL HISTORY:

Answer to these questions help us to provide safe and effective dental care personalized to your individual needs.

Are any of your teeth sensitive to:
Hot / Cold **YES / NO**
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Sweets **YES / NO**
Biting / Chewing **YES/ NO**

Do you:
Notice any odors or bad tastes? **YES / NO**
Frequently get cold sores or ulcers? **YES / NO**
Gums hurt / bleed? **YES / NO**
Have any loose teeth? **YES / NO**
Get food caught in between your teeth? **YES / NO**
Clench / Grind your teeth while awake / sleep? **YES / NO**
Have tired jaws, especially in the morning? **YES / NO**
Have a hard time opening wide? **YES / NO**
Mouth breathe while awake or asleep? **YES / NO**
Hold foreign objects with your teeth? **YES / NO**
Chew ice often? **YES / NO**
Have you been diagnosed with TMJ ? YES / NO

Have you experienced any of the following?
Clicking or popping of the jaw? **YES / NO**
Pain in the jaw joint area near the ear? **YES / NO**
Difficulty in opening or closing your mouth? **YES / NO**
Headaches, neck, or shoulder aches frequently? **YES / NO**
Have you ever had oral / facial surgery? **YES / NO**
Do you have acid reflux ? **YES / NO**

When was your last dental visit? _____ Treatment:_____
When were your last dental x-rays?:_____
How often do you have dental exams?:_____
How often do you brush your teeth?:_____
Do you floss your teeth?_____
What other dental aides do you use? (electric brush, toothpick)_____

Do you have any dental problems that you are aware of now?_____

Do you feel nervous about dental treatment? If yes, explain:_____

Ocean Drive
DENTISTRY

CANCELLATION POLICY

Routine appointments require a 24-hour advance notice to reschedule.

This will allow us time to offer your reserved appointment to someone who is waiting for an appointment and may also be in pain.

We know and understand things happen in life like flat tires, illness, and unforeseen circumstances. If you just kindly let us know, we can help another patient with a dental emergency instead.

Thank you.

Financial Arrangements:

Payment is due at the time of service. Patients with insurance will be expected to pay their estimated patient portion, which is calculated based upon the information we receive from the particular insurance company. **This estimated amount will be due on or before the day of service.** Any balance due after the insurance has paid will be billed to the patient and due within thirty (30) days of the statement date.

All payment options: CASH – CASHIER'S CHECK – PERSONAL CHECK
MASTERCARD – VISA – DISCOVER – AMEX

Patient Financing – We work with a financial organization that will allow you to get the treatment you need! Payments are spread out over 12 months, including no interest payments!

CareCredit®
Making care possible...today.

Our mission is to help you achieve the best possible dental health. Our job is to evaluate the state of your oral health, and then discuss with you our findings and potential treatment options. We will always give you all of the options that pertain to your condition. Your job is to determine what treatment option is best for **you**, and also what pace you would be comfortable with. We will gladly respect your decisions.

_____

Signature: Date:

OCEAN DRIVE DENTISTRY OFFICE POLICY REGARDING INSURANCE:

YOUR DENTAL INSRUANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. THE RESPONSIBILITY OF PAYMENT ULTIMATLEY LIES WITH THE PATIENT, NOT THE INSURANCE COMPANY. AS A COURTESY, WE WILL FILE YOUR CLAIM ON YOUR BEHALF. FAILURE TO PROVIDE OUR OFFICE WITH ALL OF THE INFORMATION NECESSARY TO FILE YOUR INSURANCE CLAIM WILL REQUIRE FULL PAYMENT AT THE TIME OF SERVICE. ANY PORTION OF TREATMENT THAT THE INSURANCE DOES NOT COVER, FOR WHATEVER REASON, IS THE PATIENT'S RESPONSIBILTY. A STATEMENT WILL BE SENT TO THE PATIENT FOR ANY BALANCE WHICH IS NOT PAID BY THE INSURANCE COMPANY.

I UNDERSTAND THAT I AM REQUIRED TO PAY MY ESTIMATED PATIENT PORTION AND ANY DEDUCTIBLE DUE TO OCEAN DRIVE DENTISTRY AT THE TIME OF MY VISIT. I HEREBY AUTHORIZE THE RELEASE OF ANY DENTAL INFORMATION THAT IS NEDED TO FILE MY INSURANCE. I CONSENT TO TREATMENT FOR MYSELF/FAMILY UNDER 18 YEARS OLD. I HAVE READ THE ABOVE STATEMENTS AND UNDERSAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL AFTER 45 DAYS OF MY TREATMENT, REGARDLESS OF ANY DELAY IN PAYMENT(S) BY MY INSURANCE COMPANY.

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SIGNATURE: DATE:

UPDATED AS OF FEBRUARY 2023