Tampa Bay DENTAL ASSOCIATES

767 Cypress Village Blvd., Ruskin, FL 33573
Phone: 813-655-9944 Fax: 813-655-9945

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ Family Status: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell/Other: _____

Email: _____ Gender: M____ F_____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact _____ Contact Phone_____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Allergies _____
- ☐ Allergy- Aspirin
- ☐ Allergy- Codeine
- ☐ Allergy-Latex
- ☐ Allergy-Penicillin
- ☐ Allergy-Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ GERD
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: _____
  _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you currently taking any medication, including non-prescription medications? ☐ Yes ☐ No
  If yes, please list on additional page attached.
- Do you use tobacco products? ☐ Yes ☐ No
- Do you use alcohol or any other drugs? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Office Use Only: x-Rays Received: None _____ Premed Required: Yes _____ No _____

FMX/Date: _____ BWX/Date: _____ RX Needed:_____

Panorex/Date: _____ Other/Date_____ Medical History Reviewed: _____(initial/date)

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Consent for Services

As a condition of your treatment by this office, payment for services is due at the time services are rendered unless financial arrangements have been made in advance. A fee may be charged for cancellations or rescheduling of appointments if less than 48 hours notice is given.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed.

Patients who carry dental insurance understand that they are responsible for their portion of dental treatment and any remaining balance after insurance has paid. This office cannot render services on the assumption that our charges will be paid in full by your insurance company, patient is to understand that fees given to them are an estimate only. I authorize the use of my signature on all insurance submissions and assign all insurance benefits directly to **Tampa Bay Dental Associates.**

I hereby authorize **Tampa Bay Dental Associates**, (collectively referred to as "Practice") to use and disclose the entire medical record, in accordance with our Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Practice to use and disclose verbally, by mail, fax or unencrypted e-mail my information as stated in the NOPP.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party