Sarasota Smile Design

3800 Clark Rd.
Sarasota, Florida 34233
(941) 927-5411
www.sarasotasmiledesign.com

PATIENT REGISTRATION / CONSENT

Acct. No:		Chart No:	

PATIENT DATA

TODAY'S DATE:

SOCIAL SECURITY #:

PATIENT (LAST) (FIRST) (MIDDLE)	SEX ☐ M ☐ F	BIRTH DATE Month / Day / Year
ADDRESS (No.) (Street) (City) (State) (Zip)		PHONE (Home) (Work)
EMAIL ADDRESS	EMPLOYER	

RESPONSIBLE AGENT (Who will pay for patient's services)

NAME (LAST) (FIRST) (MIDDLE)	RELATIONSHIP TO PATIENT ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER
BILLING ADDRESS (No.) (Street) (City) (State) (Zip)	PHONE (Home) (Work)
PLACE OF EMPLOYMENT (Name) (Address)	PHONE NO. FOR MAKING APPOINTMENTS Before 5.00 p.m. After 5.00 p.m.
DO YOU HAVE INSURANCE? ☐ YES ☐ NO IF YES, PLEASE FILL OUT SEPARATE FORM FOR INSURANCE	RESPONSIBLE AGENT'S SOCIAL SECURITY NUMBER

Who can we nofify in case of emergency?

NAME (LAST) (FIRST)	RELATIONSHIP TO PATIENT
ADDRESS (No.) (Street) (City) (State)	PHONE NO. FOR MAKING APPOINTMENTS Before 5.00 p.m. After 5.00 p.m.

CONSENT TO TREATMENT: I authorize the rendering of diagnostic and treatment procedures, including local anesthesia by authorizing agents and employees of Sarasota Smile Design, Dr. Jenifer C. Back and the dental staff, or their designees, as may in their professional judgement be deemed necessary or beneficial.
Further, I authorize the use of my patient records and photographs for teaching and printing in scientific publications. All diagnostic aids, such as radiographs, are the property of

RELEASE OF INFORMATION: Authorization is granted to the office and its staff to release partinent information from the patient's record to any insurance company or agency which is legally responsible for all or any part of the office service fees for treatment rendered. It is understood that release of information for any other reason than that necessary to secure payment for services rendered requires an additional authorization from patient.

PAYMENT AUTHORIZATION: I hereby authorize payment directly to Sarasota Smile Design of the insurance benefits otherwise payable to me, unless special arrangement are made.

Witness

Signature of patient or responsible agent

Date

If responsible agent, relationship to patient

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DENTAL HISTORY

PATIENT'S NAME _____ **DATE** _____

1. What is your primary dental concern at this time? _____
2. What is the name and address of your previsou dentist? _____
3. When did you last see your dentist? _____
4. What was your problem at that time? _____
5. When were your last dental x-rays taken? _____
6. How often do you brush your teeth? _____
7. How often do you floss your teeth? _____
8. What other aids do you use when cleaning your teeth? _____
9. Tick any of the following which you may have:

- ☐ Pain in face
- ☐ Pain inside mouth
- ☐ Pain in your ears
- ☐ Frequent headaches
- ☐ Jaw joint sounds
- ☐ Jaw locking or catching
- ☐ Jaw pain or aching
- ☐ Clenching or grinding of
- ☐ Problem chewing
- ☐ Difficulty opening your mouth
- ☐ Difficulty closing your mouth
- ☐ Recent change in your bite
- ☐ Teeth sensitive to heat
- ☐ Teeth sinsitive to cold
- ☐ Difficulty flossing between teeth
- ☐ Difficulty brushing teeth
- ☐ Food wedging between teeth
- ☐ Poorly functioning teeth
- ☐ Poorly fitting complete Denture
- ☐ Poorly fitting partial denture
- ☐ Lump or swelling in mouth
- ☐ Dry mouth
  Sores or uncers in mouth
- ☐ White, red or brown lesions in mouth
- ☐ Bad Breath
- ☐ Discolored teeth
- ☐ Soft teeth (susceptible to decay)
- ☐ Loose teeth
- ☐ Missing teeth
- ☐ Crooked teeth
- ☐ Sore gums
- ☐ Facial swelling

Problem or condition not listed?
If yes, please list

_____

_____

10. Are you presently experiencing any dental pain or discomfort? ☐ Yes ☐ No
    Have you sought care for this problem or are you taking any medicine for this problem? ☐ Yes ☐ No

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11.	Do you have any special concerns about your mouth or teeth?	☐ Yes	☐ No
12.	Are you nervous about receiving dental treatment?	☐ Yes	☐ No
13.	Have you ever had an unpleasant experience in a dental office?	☐ Yes	☐ No
14.	Have you ever experienced complications with dental treatment?	☐ Yes	☐ No
15.	Do your gums bleed when you brush and/or floos?	☐ Yes	☐ No
16.	Have you ever been giving instructions on how to brush and/or floss your teeth?	☐ Yes	☐ No
17.	Have you ever been treated for gum disease?	☐ Yes	☐ No
18.	Have you ever had an injury to your face, head or neck?	☐ Yes	☐ No
19.	Do you use tobacoo products in any form (smoking, chewing, snuff)?	☐ Yes	☐ No
20.	Do you have any oral habits which may affect your dental health?	☐ Yes	☐ No
21.	Do you like the way your teeth look?	☐ Yes	☐ No
22.	Have you ever worn braces or received orthodontic treatment?	☐ Yes	☐ No
23.	Do you receive any flouride treatment for your teeth?	☐ Yes	☐ No
24.	Do you have any dental problems which are not listed above?	☐ Yes	☐ No

FOR CHILD PATIENT:

25.	Has your child ever been treated in an emergency room?	☐ Yes	☐ No
26.	Does your child have emotional, mental or nervous disorders?	☐ Yes	☐ No
27.	Do you think that your child will be an uncooperative dental patient?	☐ Yes	☐ No
28.	Has your child ever sucked their thumb or fingers?	☐ Yes	☐ No
29.	Has your child inherited any family dental characteristics?	☐ Yes	☐ No
30.	Does your child receive any form of flouride?	☐ Yes	☐ No

To the best of my knowledge, the proceeding answers are true and correct. If there are every any changes in my dental health, I will inform the doctor at the next appointment.

Date _____ Patient (Parent) Signature _____

DENTAL HISTORY/EVALUATION UPDATE

Date	Addition		

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MEDICAL HISTORY

PATIENT'S NAME _____ **DATE** _____

Please check the box for any condition which you have ad in the past or have now. (Parents or Gaurdian) If you are completing this form for your child, Please indicate your child's health status by checking the appropriate box.

(1) CARDIOVASCULAR

- Heart Failure ❑
- Heart Disease or Attack ❑
- Angina Pectoris or Chest Pain ❑
- High Blood Pressure ❑
- Heart Murmur ❑
- Mitral Valve Prolapse ❑
- Rheumatic Fever ❑
- Congenital Heart Defect or Lesion ❑
- Artificial Heart Valve ❑
- Arrhythmias ❑
- Heart Pacemaker or Defibrillator ❑
- Heart Surgery or Transplant ❑
- Other Heart Problems ❑
- Stroke ❑
- Aneurysm ❑

(2) HEMATOLOGIC

- Blood Transfusion ❑
- Anemia ❑
- Hemophilia ❑
- Leukemia ❑
- Sickle Cell (Anemia) Disease ❑
- Tendency to Bleed Longer than Normal ❑

(3) NEURAL/SENSORY

- Eye Pain ❑
- Vision Problems ❑
- Glaucoma ❑
- Earaches, Ringing in Ears ❑
- Hearing Loss ❑
- Severe Headaches ❑
- Fainting or Dizzy Spells ❑
- Epilepsy, Seizures or Convulsions ❑
- Nervousness ❑
- Psychiatric Treatment ❑

(4) GASTROINTESTINAL

- Stomach/Intestinal Ulcers ❑
- Gastritis ❑
- Colitis ❑
- Persistent Diarrhea ❑
- Hepatitis ❑
- Liver Disease ❑
- Yellow Jaundice ❑
- Cirrhosis ❑

(5) RESPIRATORY

- Hay Fever ❑
- Sinus Trouble ❑
- Allergies or Hives ❑
- Asthma ❑
- Chronic Cough ❑
- Empysema ❑
- Tuberculosis ❑
- Breathing Difficulties ❑

(6) DERMAL/MC/MS

- Allergy to Latex (Rubber) ❑
- Skin Rash ❑
- Dark Mole(s) (Recent Changes in appearance) ❑
- Night Sweats ❑
- Sore Muscles ❑
- Stiff Joints ❑
- Arthritis ❑
- Artificial Joint ❑
- Fever Blister; Cold Sore ❑
- Mouth Ulcers or Canker Sores ❑
- Clolored or Discovered Areas in Mouth ❑

(7) ENDOCRINE

- Diabetes ❑
- Thyroid Disease ❑

(8) URINARY/ST

- Urinate Frequently ❑
- Kidney, Bladder Problem ❑
- Sexually Transmitted Disease (Syphilis, Gonorrhea, Chlamydia or Genital Herpes) ❑
- HIV Positive ❑

(9) OTHER CONDITIONS

- Frequent Sore Throats ❑
- Enlarged Lymph Node or "Gland" ❑
- Use Tobacco ❑
- Use Alcohol ❑
- Drug or Alcohol Addition (Recovering or Current) ❑
- Tumor or Cancer ❑
- X-ray or Cobalt Treatment ❑
- Chemotherapy ❑
- Disease, Problem or Condition Not Listed ❑

If yes, list

_____

_____

_____

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10. Are you currently under the care of a physician? ❑ yes ❑ no
Physician Name _____ Address _____
Phone No. _____ Last Appointment Date _____
For What? _____

11. Are you taking (or supposed to be taking) any medicine, drugs, or pills of any kind? ❑ yes ❑ no
If yes, what kind and dose

_____

_____

_____

12. Have you taken Cortisone or other steroids in the past 12 months? ❑ yes ❑ no
13. Do you have reactions or allergies to drugs or medicines? ❑ yes ❑ no
14. Have you had a reaction to dental or general anesthetic? ❑ yes ❑ no
15. have you ever had any operations or surgery? ❑ yes ❑ no
Describe the problem and any complications

_____

16. Have you ever been hospitalized? ❑ yes ❑ no
17. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ❑ yes ❑ no
18. Do your ankles swell during the day? ❑ yes ❑ no
19. Do you sleep on two or more pillows? ❑ yes ❑ no
20. Have you unintentionally lost or gained more than 10 pounds in the last year? ❑ yes ❑ no
21. Are you on a special diet? ❑ yes ❑ no
22. Does your occupation bring you in contact with blood, blood products or needles? ❑ yes ❑ no
23 (WOMEN) Are you pregnant or trying to get pregnant? ❑ yes ❑ no

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or if my medicines change, I will inform the dentist at the next appointment without fail.

_____ _____
Date Patient, Parent or Guardian Signature

Review and update

_____ _____ _____
_____ _____ _____
Date Changes in Health Status

Height _____; Weight _____; BP _____; Pulse _____; Resp. _____; Temp. _____

HEALTH COMMENTS & SUMMARY: **ASA** **I** **II** **III** **IV**