Periodontics & Oral Implantology Center of South Florida

Online form www.drmyones.com

Patient Information

Date_____

Patient Name:_____
Last First MI

Male_____Female_____ Married_____Single_____Child_____

Birth Date:_____

Street Address_____

Street Apt.# _____City_____ Zip Code_____

Home Tel #:_____(Work):_____

Cell Tel #:_____

Best time to call_____AM_____PM

E-Mail Address_____

Employment Information
The following is for: the patient the person responsible for payment

Social Security #:_____

Employer Name:_____Occupation:_____

Address:_____
Street City State Zip Code

Spouse or Responsible Party Information
The following is information about the patient's spouse or the person responsible for payment

Name:_____
Last First MI

Social Security #:_____

Home Tel #:_____

Work Tel #:_____

Address:_____
Street Apt.# City Zip Code

Primary Dental Insurance Coverage

Subscriber Name:_____Relationship to Patient:_____

Subscriber Address:_____

Ss#:_____-_____-_____ Employer:_____

Dob:_____/_____/_____

Address:_____

Plan Name:_____Group #:_____

Insurance Co:_____ Indiv. Yearly Deduct:_____

Address:_____ Family Yearly Deduct:_____

Secondary Dental Insurance Coverage

Subscriber Name:_____Relationship to Patient:_____

Subscriber Address:_____

Ss#:_____-_____-_____

Employer:_____

Dob:_____/_____/_____

Address:_____

Plan
Name:_____

Group #:_____

Insurance Co:_____Indiv. Yearly Deduct:_____

Address:_____Family Yearly Deduct:_____

Health Information

Date of last dental visit:_____

Reason for visit_____

Have you ever had any of the following? Please check those that apply:
□ Aids
□ Allergies
□ List allergies to: (medication, latex, etc) _____
□ Anemia
□ Asthma
□ Arthritis or Rheumatism
□ Artificial Heart Valve/Joint Heart Disease
□ Blood Disease High Blood Pressure
□ Cancer
□ Chest Pain
□ Chemotherapy
□ Diabetes
□ Dizziness
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Heart Murmur
□ Hepatitis or Liver Disease
□ Pacemaker
□ Radiation Therapy
□ Respiratory Problems
□ Sinus Problems
□ Stroke
□ Tuberculosis
□ Venereal Disease
□ Other:
□ Please list other _____

Female Patients:
□ Thyroid Trouble
□ Pregnant
□ Taking birth control pills

Have you ever had any complications following dental treatment?
Yes □ No □

If yes, please explain_____

Are you currently under the care of a physician?
Yes □ No □

If yes, please explain:_____

Name of Physician:_____Phone:_____

Do you have other health problems?
Yes □ No □

If yes, please
explain:_____

List medications you are currently taking:_____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I am responsible to inform this office of any change in health information.

_____Date_____
Signature of patient, parent, or guardian

Consent for Service
As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time of service rendered.

Patients who carry dental insurance understand that all dental services performed are charged directly to the patient and that he or she is personally responsible for payment of all dental services. PERIODONTICS & ORAL IMPLANTOLOGY CENTER OF SOUTH FLORIDA will help prepare the patient's insurance or assist in making collections from insurance companies and will credit any such collections to the patient's account. Howerver, we cannot render services on the assumption that our charges will be paid by an insurance company. In consideration for the professional sevices rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered. I further agree that a waiver of any time or condition there under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my perpermission for PERIODONTICS & ORAL IMPLANTOLOGY CENTER OF SOUTH FLORIDA and its assignee, to telephone me at home or work to discuss matters related to my dental care.

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

_____Date:_____
Signature of patient or responsible party

Relationship to patient:_____