

VITALITY DENTAL GROUP PLANTATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Email: _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Person Responsible for Account if Other than Patient

Name: _____ Relation to Patient: _____ Phone: _____

Date of Birth: _____ Social Security #: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relation to you: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse Information

Name: _____ Birth Date: _____ Social Security #: _____

Employer: _____ Phone: _____ Work Phone: _____

Insurance Information

Primary Insurance Company: _____ Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's ID #: _____ Group #: _____

Employer: _____ Insurance Company Phone: _____

Secondary Insurance Company: _____ Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's ID #: _____ Group #: _____

Employer: _____ Insurance Company Phone: _____

I understand that I am responsible for payment of services rendered by Vitality Dental, and also responsible for paying any co-payment and deductible that my insurance does not cover.

Signature: _____ Date: _____

DENTAL HISTORY

What concerns you most? _____

Are you having discomfort at this time? _____ What is the discomfort? _____

How long since you have been to a dentist? _____ Did you have X-Rays? _____ What else was done? _____

Are your teeth sensitive to: heat? _____ cold? _____ sweets? _____ sour? _____ pressure? _____

Have you ever had your teeth straightened? _____ If so, when? _____ Did you have traditional braces? _____

How often do you brush your teeth? _____ How often do you use dental floss? _____

Do you have bleeding gums? _____ Have you ever had gum treatment? _____ When? _____

Do you grind or clench your teeth? _____ Do you hear popping or clicking noises when you chew? _____

Do you have any pain around either of your ears? _____ Any swelling or lumps in your mouth? _____

Do you have any fear of dental treatment? _____

How do you feel about the appearance of your teeth? _____

MEDICAL HISTORY

Are you currently under a Physicians care? _____ Physician's Name _____

Physician's Address _____ Physician's Phone _____

Do you or have you experienced any of the following? (Please circle Y/N)

Y N Abnormal Bleeding	Y N Colitis	Y N Heart Murmur	Y N Liver Disease
Y N Alcohol Use	Y N Congenital Heart Defect	Y N Heart Surgery	Y N Lupus
Y N Anemia	Y N Diabetes	Y N Hemophilia	Y N Pacemaker
Y N Artificial Bones/Joints	Y N Emphysema	Y N Hepatitis	Y N Radiation Treatment
Y N Artificial Valves	Y N Fever Blisters	Y N Herpes	Y N Seizures
Y N Asthma	Y N Glaucoma	Y N High Blood Pressure	Y N Tobacco Use (Smoke/Chew)
Y N Cancer	Y N Headaches	Y N HIV+/AIDS	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Heart Attack	Y N Kidney Problems	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced. _____

Are you allergic to any of the following? (Please circle Y/N)

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry/Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions: _____

Please list any and all medications you are currently taking: _____

For Women: Are you taking birth control pills? _____ Are you pregnant? _____ Week #: _____ Are you nursing? _____

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Vitality Dental Group any changes in my medical status. I authorize dental staff to perform the necessary dental services I may need, including x-rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my dental needs.

Signature: _____ Date: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.