NEW PATIENT INFORMATION

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us – we will be happy to help.

Name: ___________________________ ____________________________ _____________________________

First Middle Last

Birth date: ________/______/________ Age: _________________ Sex: [] Male []Female

S.S. #: ____ [] Single [] Married [] Child [] Other

Home Address: ____Apt #______________

City: ______________________________________ State: _________________ Zip: ______________________

Home Phone: (________) ________________________ Work: (________) _______________________________

Cell: (_________) _________________________ Email Address: ______________________________________

Occupation: ____________________________________ Employer: _____________________________________

Employers Address: ____

City ___________________________ State: _________ Zip: ____________

Whom may we thank for referring you? ____

PERSON RESPONSIBLE FOR ACCOUNT

[] Same as above

Name: ____ Birth date: ________/______/________

Relation: ______________________________________S.S.#: _____________________________

Billing Address: ____Apt #______________

City: ______________________________________ State: __________________ Zip: ______________________

Home Phone: (________) ________________________ Work: (________) _______________________________

Cell: (_________) _________________________ Email Address: ______________________________________

Occupation: ____________________________________ Employer: _____________________________________

SPOUSE INFORMATION

[] Same as above

Name: ____ Birth date: ________/______/________

Occupation: ____________________________________ Employer: _____________________________________

PLEASE FILL OUT THE BACK OF THIS PAGE ➜

Medical History Information

Name of Physician: ____________________________________ Phone: (_______) _______________________

Name of Dentist: ______________________________________ Phone: (_______) _______________________

Last Dental appointment date and reason:____

Do you have or have ever had any of the following? Please check those that apply:

[ ] Allergies/Hay Fever	[ ] Diabetes	[ ] Heart Surgery	[ ] Rheumatic Fever
[ ] Anemia	[ ] Epilepsy or Seizures	[ ] Hepatitis	[ ] Rheumatism
[ ] Angina	[ ] Excessive Thirst	[ ] High Blood Pressure	[ ] Sickle Cell Disease
[ ] Arthritis	[ ] Fainting or Dizziness	[ ] HIV/ AIDS	[ ] Sinus Problems
[ ] Artificial Joints	[ ] Fever Blisters/Cold Sores	[ ] Kidney problems	[ ] Stroke
[ ] Artificial Heart Valves	[ ] Frequent Cough	[ ] Liver Problems	[ ] Surgical Shunt
[ ] Asthma	[ ] Glaucoma	[ ] Mental Disorders	[ ] Thyroid Problems
[ ] Breathing Problems	[ ] Heart Disorder	[ ] Mitral valve prolapse	[ ] Tuberculosis
[ ] Cancer	[ ] Heart Infection	[ ] Osteoporosis	[ ] Ulcers
[ ] Chemical Dependency	[ ] Heart Murmur	[ ] Radiation Treatment	[ ] Venereal Disease
[ ] Chemotherapy	[ ] Heart Pace Maker	[ ] Respiratory Problems	[ ] Yellow Jaundice

*This condition may require antibiotic premedication for each dental procedure.

YES NO

[] [] Do you have any health problems that were not listed above or need further clarifications?

If yes, explain: ____

[] [] Are you now under the care of a physician?

If yes, explain: ____

[] [] Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, explain: ____

[] [] Are you taking any medications?

If yes, list: ____

[] [] Are you allergic to any medications or substances? If yes, please check box below:

[] Aspirin [] Penicillin [] Codeine [] Iodine [] Metal [] Latex [] Other _______________

WOMEN (Please check): [] Pregnant [] Trying to get pregnant [] Nursing [] Taking oral Contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X____ Date _________________________________

Signature of patient, parent or guardian

Patient's Name: _____________________________Date of Birth: ____/____/______ Date: ______________

Dental Insurance Information

Do you have Dental Insurance: **[]** Yes **[]** No

Primary Insurance

Insurance Company Name: ____

Insurance Company Phone #: ____

Insured's Name: _________________________________ Insured's Birth date:________/_________/_________

Insured's S.S # : _________________________________ Relation to Patient: _____________________________

Group#: _________________________________ Insured's Employer: __________________________________

Do you have Secondary Insurance?____

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment please provide us at least 24 hours so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

FINANCIAL POLICY

The Undersigned acknowledges and agrees that the primary responsibility for any changes rendered for dental services is the primary responsibility of the undersigned, and not of any public or private insurance company or agency or the attorneys of the undersigned. I understand that the doctor's fees are their own and are in no way related to the allowable charges of any public or private insurance carrier. It is further specifically understood and agreed that if collection procedures must be instituted relative to any charges made hereunder, the undersigned will be responsible for all fees (regardless whether suit is filled or not). All collection costs, including reasonable attorney's fees, court costs, office costs incident to collection procedures in addition to amount owed for dental services, together with service charges at the rate of 1.5% per month commencing 30 days after first billing. It is understood that venue of this agreement will be Dade County, Florida.
Payment options: For your convenience we accept Cash, Check, Visa, MasterCard and Amex.
Fees: Returned Checks are subject to a $30.00 accounting fee.

AUTHORIZATION AND CONSENT

General Consent to Treatment
I agree and consent to a dental examination by Dr. Amelinckx. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any dental procedures performed.
Release of Information
I authorize Dr. Amelinckx to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.
Assignment of Insurance Benefits
I authorize and request my insurance company to pay my benefits directly to Dr. Amelinckx.
Photography Release
I authorize Dr. Amelinckx to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize her to show these photographs to other patients to better explain their treatment options.

I understand and will comply with **Appointment Policy**.
I understand and will comply with the office **Financial policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize **Photographs** to be taken of me and shown to other patients.

X ____ Date ________________________
Signature of patient, parent or guardian