ATLANTIS DENTAL CARE, P.A. 5851 S. CONGRESS AVENUE. ATLANTIS.FLORIDA.33462
Ph: 561-965-9988 Fax: 561-965-0385 Email: **AtlantisDental@comcast.net**
www.AtlantisDentist.com

WELCOME TO OUR OFFICE

PATIENT INFORMATION

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

Date of Birth: _____ Age: _____ Preferred Name: _____

Patient is: Policy Holder Y/N Responsible Party Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cellular: _____ Home: _____ Work: _____

BEST NUMBER AND TIMES TO REACH YOU: _____

Email: _____

Marital Status: ____Sex: ____Driver's License #:_____

Occupation: _____

INSURANCE INFORMATION

Name of Insured: _____Relationship: Self / Spouse / Child / Other

Insured SSN #: _____ Insured Date of Birth: _____

Employer:_____

Insurance Company: _____ Group Name: _____

Insurance Phone #: _____ Member ID: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____Relation: _____ Phone#:_____

How did you hear about our office? _____

Names of other family members who are patients here?_____

I agree to have email and or texting communication; I am aware there is some level of risk that 3rd parties might be able to read unencrypted emails or text messages. I have received copy of notice of privacy practices.

PATIENT SIGNATURE: _____ DATE:_____

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MEDICAL DR.NAME:_____ PHONE: _____ FAX:_____

PREFERRED PHARMACY NAME:_____ PHONE: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women:
Pregnant/Trying to get pregnant? ◯ Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

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OFFICE USE ONLY

REVIEWING DENTIST SIGNATURE: _____ DATE: _____

Medical clearance Needed or Not?

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Our commitment is to help remove misunderstandings or barriers, so that you can receive the dental treatment you need and desire. Your clear understanding of our policies plays an important role in our relationship. Please ask if you have any questions about our fees, financial and scheduling policy, or our/your responsibility.

OFFICE POLICY

*Insurance: Our experienced team is committed to helping patients maximize their dental benefits. Insurance policies vary greatly. Due to the complexity of insurance contracts we can only **ESTIMATE** in good faith, what your insurance will pay, not guarantee your coverage. Your estimated patient portion must be paid at the time the service is rendered, unless prior financial arrangements have been made. As a service to our patients, we will bill your insurance company for services, allowing 30 days for them to render payment. After 30 days, you are responsible for the entire balance due in full. If you have any questions, our courteous office staff is always available to answer them for you. You will be informed of treatment planned and associated fees.

*Your Responsibility: Keeping us informed of changes in your health, medications, address, dental insurance, contact information, account information and any information that helps us manage your care. Cancellations and Not showing up!! Please let us know.

*Reservation fee: on Doctor's schedule - this shows your commitment to treatment and this payment will be towards your treatment.

*Payment options: We accept cash, checks, debit and most credit cards (Master Card, Visa, Discover, and American Express). We also offer flexible financing options through 3rd Party Financing because we understand that monthly payments can help patients fit the cost of dental treatment into their budgets.

*Service Charges: The policy of this office is to charge 1.5% monthly interest (18% annual percentage rate) or billing charge that will be applied to all accounts over 90 days past due. We will also charge **$35.00** for any returned checks.

*Collection Fees: Fees incurred to collect payment, will be billed to and payable by the patient's account holder.

*Assignment of Benefits: I hereby authorize assignment of payment of my dental insurance benefits to **ATLANTIS DENTAL CARE,P.A**.

*Financial Agreements: The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office. I understand and agree to this financial policy.

Patient/Responsible Party Name	Signature	Date

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CONSENT FOR TREATMENT

We are here to provide dental service to you in the most beneficial way possible. This requires much understanding. In order to educate and inform you, we would like you to read this consent for treatment.

_____ Initial
I realize that unless I provide the doctor with an accurate and complete medical and dental history, complications may result. I am aware that the dentist may need to confer with my physician. I agree to provide all information. I will notify the office if there is any change in my medical status.

_____ Initial
I understand that certain parts of my treatment may be performed by licensed, supervised paraprofessionals other than the dentist. I thus consent to treatment by those paraprofessionals.

_____ Initial
I understand that x-rays, photographs or models of my mouth may be necessary for an accurate diagnosis and treatment. I understand that these are the property of the doctor, but that copies are available on request at an additional cost. I consent to the use of these diagnostic tests unless I so state prior to their implementation.

_____ Initial
I recognize that in cleaning teeth the dentist or paraprofessional may use a modern and efficient method known as ultrasonic cleaning. I understand that other electronic and mechanical devices will also be used in my treatment. I consent to such procedures unless I object to the use of such equipment in a timely fashion. I am aware that pacemakers are sensitive to some of this equipment and I will immediately inform all personnel if I have a pacemaker.

_____ Initial
I realize that in the course of treatment, drugs and medications may be used. I realize that any risks concerned with drugs will be explained to me, If I have questions, I will ask. I know that occasionally a reaction may occur to these drugs or local anesthetics. I understand that some risks may be involved and that if I have any questions concerning their use, I should discuss this with the doctor. I realize that if I am experiencing any adverse reactions to drugs, medication or treatment, I should immediately advise the doctors or their assistants.

_____ Initial
I understand that the doctor is not responsible for previously placed dental appliances or previous dental treatment. I understand that, in the course of treatment, these previously made dental appliances or other existing dentistry may need adjustment, cost will be explained first.

_____ Initial
I know that I should listen carefully when the dentist advises me of any change in the plan of treatment which may result in adjustments of treatment, change in fee or time involved. I realize that alternative treatment plans, if any, will be discussed with me prior to my acceptance of treatment.

_____ Initial
I agree that fees are payable when the service is rendered unless specific financial arrangements are made prior to dental treatment. Arrangements are made with the office manager.

_____ Initial
I realize that guarantees of results or absolute satisfaction are not possible in dental health service. I realize that personal articles brought into the office are my responsibility.

I have read and understand the contents of this treatment and agree to the provisions of it. If I have any questions I will ask the doctor.

Patient Name (print)_____

Signature_____Date_____

Signature of Parent or Guardian (for minor child) _____Date_____

THANK YOU.

Your cooperation, consent for treatment and open communication will greatly add to your dental success and it will make working toward our mutual goals much easier.