About You (Patient)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name (First) (MI) (Last)

I prefer to be called

Home Address

City State Zip

Phone (Home) (Mobile)

Email

Birthdate SS#

Employer How Long there

Occupation Phone

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact

In the event of an emergency, is there a person you would like us to contact?

Name of contact

Relationship

Phone # Mobile #

Referral Information

How did you hear about us/Who can we thank for referring you?

☐ Google/Internet
☐ Insurance Company
☐ Church Bulletin
☐ Sarasota Magazine
☐ Facebook
☐ Instagram
☐ Newspaper
☐ Road Sign
☐ Cardinal Mooney H.S.
☐ Walk-In
☐ Integrated Dental Team Member

Who? _____

☐ Integrated Dental Patient:

Who? _____

☐ Friend or Family Member:

Who? _____

☐ Other: _____

Office Consents

Please **initial** in each space

Consent of Care

_____ I agree and give my consent for Integrated Dental to provide dental care that is considered necessary and proper in diagnosing and treatment my dental condition. I understand that during RESTORATIVE treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination, the most common of which being root canal therapy following routine restorative procedures such as a crown. I give my permission to the dentist to make any/all changes to treatment as necessary in the interest of my oral health.

Cancellation Policy

_____ It is the patient's responsibility to give Integrated Dental 48-hour notice if they will be unable to attend an appointment. Late cancellations are subject to a $50 per hour fee or the forfeit of your sedation booking deposit. This policy makes it possible for Integrated Dental to offer appointments to all patients in a timely and effective manner.

Deposit Policy

_____ Because of our growing patient base and limited schedule availability, Integrated Dental requires a deposit upon booking any restorative and/or deep cleaning appointment. A deposit of 25% of your estimated patient portion will be collected at the time of booking. This deposit is non-refundable if you cancel within our 48- hour cancellation policy or no-show. This policy ensures Integrated Dental's schedule is used wisely and effectively.

Acknowledgement of Receipt of Privacy Practices

_____ I acknowledge and agree that I have been informed to read the Notice of Privacy Practices Policy on Integrated Dentals' website. In addition, I acknowledge I can request a copy of Integrated Dental's Notice of Privacy Practices in writing at any time.

Dental Insurance

Name of Dental Insurance Company: _____ Group # (Plan, Local, or Policy #) _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber Date of Birth ___/___/___ Subscriber SS #: ___-___-___ Subscriber Employer: _____

Dental History

Reason for today's dental visit: _____

Date of last dental exam: ___/___/___ Date of Last Dental x-rays: ___/___/___ Last dental cleaning: ___/___/___

Previous dental office/dentist: _____ Phone Number: _____

How often do you brush? _____ How often do you floss? _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping TMJ/TMD
- ☐ Food collection between teeth
- ☐ Periodontal disease/treatment
- ☐ You clench/grind your teeth
- ☐ Would like to have whiter teeth
- ☐ Loose teeth
- ☐ Smoke or use tobacco
- ☐ You vape
- ☐ Sores or growths in your mouth
- ☐ You don't like your smile
- ☐ Sensitivity to (circle one)
  Cold Hot Sweets When Biting
- ☐ You have 1 or more missing teeth that you would like replaced
- ☐ You snore when sleeping
- ☐ You wear a nightguard when sleeping
- ☐ Have you ever been diagnosed or think you might suffer from sleep apnea
- ☐ You have a CPAP. Do you use it? _____

Medications

Name of Pharmacy: _____ Phone Number: _____

Please list all medication that you are currently taking, including prescription medication, over-the-counter medication, vitamins, and supplements. If you have a list already completed, please bring that to your appointment so our team can copy it for your chart.

Name of Medication	Strength and Frequency	Condition Medication Taken For

INTEGRATED DENTAL

Medical History

Physician's Name: _____ Phone Number: _____ Last Visit: _____

Have you had any serious illnesses or operations? **YES NO** If yes, please describe: _____

_____

Have you ever had a blood transfusion? **YES NO** If yes, please give approximate date(s): _____

Check (✓) if you have or have had any of the following:

- ☐ AIDS/HIV+
- ☐ Acid Reflux/GERD
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Auto Immune Disease

  _____
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatment
- ☐ Cough, Persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches/Migraines
- ☐ Heart Murmer
- ☐ Heart Attack
- ☐ Heart Problems:
  Describe: _____

  _____
- ☐ Hemophilia
- ☐ Hepatitis (if yes, circle type)
  A B C D E
- ☐ High blood pressure
- ☐ Herpes/Fever Blisters
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Marijuana use
- ☐ Recreational Drug Use
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Osteoporosis
  Treatment: _____

  _____
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Dental anxiety
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease/STI
- ☐ Require antibiotics prior to a dental procedure
- ☐ Take Bisphosphonates
- ☐ Other: _____

  _____

  _____

  _____

Is there anything else you would like the doctor to know? _____

_____

Allergies

Do you have any allergies? Please mark all that apply and list any that are not listed here:

☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ Sulfa

☐ Erythromycin ☐ Local Anesthetic ☐ Tetracycline ☐ Other: _____

Women Only

Are you pregnant? **YES NO** Nursing? **YES NO** Taking birth control? **YES NO** Hormone Replacement? **YES NO**

Do you have osteoporosis? **YES NO** Have you or are you taking Bisphosphonates? **YES NO**

If yes, which one? _____ When/How often? _____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: **Date:**