WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please complete this form in ink. If you have questions or need assistance, we are happy to help you, just ask.

CONFIDENTIAL

Patient Information

Name _____ I prefer to be called _____

M ☐ F ☐ Birthdate _____ Age _____ Social Security Number _____

Home Address _____
street *city* *state* *zip*

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone _____ Pager /Cell Phone _____ Email Address _____

Responsible party's name if other than patient _____ Phone _____

If a minor, parent or guardian's name _____ Phone _____

If you're a student, Name of School _____

Patient or Parent's Employer _____ Occupation _____

Patient or Parent's Employer's Address _____

_____ Patient or Parent's Employer's Phone _____

Whom may we thank for referring you to our office? _____

Who should we contact in case of an emergency? [name/phone] _____

DENTAL Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Insuring Employer _____ Phone Number _____

Address of Insuring Employer _____

Name of Insurance Co. _____ GROUP # _____ Policy ID# _____

Address of Insurance Co. _____
city state zip

MEDICAL Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Insuring Employer _____ Phone Number _____

Address of Insuring Employer _____

Name of Insurance Co. _____ GROUP # _____ Policy ID# _____

Address of Insurance Co. _____
city state zip

See other side, please.....

Patient's Physician Name_____ Phone_____

Are you currently in medical treatment? Y ☐ N ☐ If yes, please explain _____

_____ Are you currently taking any medications? Y ☐ N ☐

List all prescription and non-prescription medications you are on now. _____

_____

Do you use tobacco? Y ☐ N ☐ Do you use controlled substances? Y ☐ N ☐ Do you wear contact lenses? Y ☐N ☐

If female: Are you pregnant? Y ☐ N ☐ Nursing? Y ☐ N ☐ Taking Oral contraceptives? Y ☐ N ☐

Patient Medical History

Y or N	Condition	Y or N	Condition	Y or N	Condition
☐☐	high blood pressure	☐☐	cardiac pacemaker	☐☐	easily winded
☐☐	heart attack	☐☐	heart murmur	☐☐	stroke
☐☐	rheumatic fever	☐☐	heart surgery	☐☐	hay fever
☐☐	swollen ankles	☐☐	angina pectoris	☐☐	allergies
☐☐	fainting spells	☐☐	frequently tired	☐☐	tuberculosis
☐☐	seizures	☐☐	anemia	☐☐	recent weight loss
☐☐	asthma	☐☐	emphysema	☐☐	glaucoma
☐☐	low blood pressure	☐☐	cancer-chemotherapy	☐☐	heart trouble
☐☐	epilepsy	☐☐	arthritis	☐☐	respiratory problems
☐☐	leukemia	☐☐	joint replacement	☐☐	mitral valve prolapse
☐☐	diabetes	☐☐	hepatitis A, B, or C [if yes, circle letter]	☐☐	radiation treatment/therapy
☐☐	kidney problems	☐☐	yellow jaundice	☐☐	sinus problems
☐☐	HIV + Aids	☐☐	sexually transmitted disease	☐☐	headaches or migraines
☐☐	thyroid problems	☐☐	ulcers	☐☐	other health conditions that we should include in your health profile
☐☐	heart disease	☐☐	chest pain		

Y or N	ALLERGIC TO	Y or N	ALLERGIC TO	Y or N	ALLERGIC TO
☐☐	aspirin	☐☐	penicillin	☐☐	iodine
☐☐	codeine	☐☐	tetracycline	☐☐	latex
☐☐	dental anesthetics	☐☐	sedatives	☐☐	jewelry
☐☐	erythromycin	☐☐	metals	☐☐	other -

Patient Dental History

Y or N		Y or N		Y or N	
☐☐	Bleeding gums when brush or floss?	☐☐	Pain of any kind in teeth/gums?	☐☐	Do you grind or clench?
☐☐	Hot or cold sensitivity?	☐☐	Sores or lumps in or around mouth?	☐☐	Have you ever had orthodontia?
☐☐	Sweet or sour sensitivity?	☐☐	Any jaw or ear pain or clicking?	☐☐	Do you wear dentures or partials?

Authorization and Release

I certify that I have read & understand the above information and have accurately answered to the best of my knowledge. I understand that providing inaccurate information could be dangerous to my health. I authorize the dentist to release any information including the examination, diagnosis & treatment rendered to me or my child to my dental insurance company in order for them to reimburse me directly for services rendered by my dentist. I understand that I am responsible for payment of all services rendered on behalf or me or my dependents. SIGNATURE _____

Welcome

Advanced Dentistry of Naples
Thomas P. Hale D.D.S. P.A.
9180 Galleria Court Suite 100
Naples, FL 34109

NEW PATIENT SCREENING SLIP

Name_____

IF CHILD, PARENT OR GUARDIAN_____

E-MAIL ADDRESS _____

DATE OF BIRTH_____

SS# _ _ _ - _ _ - _ _ _ _

TELEPHONE: HOME _____**WORK** _____

REASON FOR CALL: _____

_____

DISCOMFORT? ___HOW LONG? ___SWELLING? ___TOOTHACHE? ___BLEEDING? ___

SENSITIVE TO HOT/COLD? ____BROKEN TOOTH? ____

LAST VISIT TO DENTIST _____ **LAST X-RAYS TAKEN** _____

DO YOU NEED PRE-MED? YES __ NO __ MEDICAL CONDITIONS_____

WILL HANDLE BY: CASH CHECK CREDIT CARD

WAS TOLD PAYMENT IS EXPECTED AT THE FIRST VISIT? YES___ NO___

REFERRED BY: _____

Please review our Appointment policies...

***Appointment Confirmations*:** You, as the patient, are responsible for keeping your scheduled appointment. However, as a courtesy, we will try to telephone you to confirm your appointment. Please understand that we expect you whether or not we are able to reach you.
Appointment Cancellation: A particular appointment time has been reserved for you. Therefore, we require at least 24 hours, notice of cancellation, except in cases of extreme emergency. Otherwise, there is a cancellation fee of $50 for the missed appointment.
Emergency/Urgent Care: If you have an urgent problem, please call our office at once so that we may attend to your needs.

I have read and understand the following appointment information and agree to the terms: _____