



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

Y or N	ALLERGIC TO	Y or N	ALLERGIC TO	Y or N	ALLERGIC TO
<input type="checkbox"/>	aspirin	<input type="checkbox"/>	penicillin	<input type="checkbox"/>	iodine
<input type="checkbox"/>	codeine	<input type="checkbox"/>	tetracycline	<input type="checkbox"/>	latex
<input type="checkbox"/>	dental anesthetics	<input type="checkbox"/>	sedatives	<input type="checkbox"/>	jewelry
<input type="checkbox"/>	erythromycin	<input type="checkbox"/>	metals	<input type="checkbox"/>	other -

Patient Dental History

Y or N	Y or N	Y or N			
<input type="checkbox"/>	Bleeding gums when brush or floss?	<input type="checkbox"/>	Pain of any kind in teeth/gums?	<input type="checkbox"/>	Do you grind or clench?
<input type="checkbox"/>	Hot or cold sensitivity?	<input type="checkbox"/>	Sores or lumps in or around mouth?	<input type="checkbox"/>	Have you ever had orthodontia?
<input type="checkbox"/>	Sweet or sour sensitivity?	<input type="checkbox"/>	Any jaw or ear pain or clicking?	<input type="checkbox"/>	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 of 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: _____