Ocala Dental Care
OCALA DENTAL IMPLANT CENTER

Chart #:

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Email Address: _____ Gender: _____ Marital Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact Information

Contact Person: _____ ***Relation to Patient:*** _____

Contact Number: _____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ACID REFLUX
☐ ADHD
☐ AIDS/HIV
☐ ANEMIA
☐ ANOREXIA
☐ ANXIETY
☐ ARTIFICIAL HEART VALVE
☐ ARTIFICIAL JOINTS
☐ ARTHRITIS
☐ ASTHMA
☐ BULIMIA
☐ CANCER/MALIGNANCY
☐ CEREBRAL PALSY
☐ CHEMICAL DEPENDENCY
☐ DEPRESSION
☐ EPILEPSY/SEIZURES
☐ DIABETES
☐ HEARING PROBLEMS
☐ HEART ATTACK
☐ HEART DISEASE
☐ HEART MURMUR
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ KIDNEY DISEASE
☐ LIVER PROBLEMS
☐ MITRAL VALVE PROLAPSE
☐ MONONUCLEOSIS
☐ PACEMAKER
☐ PSYCHIATRIC TREATMENT
☐ RADIATION/CHEMO
☐ RESPIRATORY DISEASE
☐ SINUS PROBLEMS
☐ STROKE
☐ TUBERCULOSIS
☐ ULCERS
☐ OTHER – PLEASE LIST:

ALLERGIES/ALLERGIC REACTIONS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ASPIRIN
☐ ANESTHETIC – LOCAL
☐ BARBITURATES
☐ OTHER – PLEASE LIST
☐ CODEINE
☐ DAIRY
☐ LATEX
☐ LACTOSE INTOLERANCE
☐ METAL SENSITIVITY
☐ NITROUS OXIDE SEDATION
☐ SLEEPING PILLS
☐ SULFA DRUGS
☐ PENICILLIN/OTHER ANTIBIOTICS

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS
☐ BLOOD THINNERS
☐ INSULIN
☐ RECREATIONAL DRUGS
☐ OTC DRUGS/ MEDICATIONS (PLEASE LIST BELOW)
☐ ANTIHISTAMINES/ALLERGY
☐ CANCER/CHEMO MEDICATIONS
☐ NITROGLYCERIN
☐ THYROID MEDICATIONS
☐ OTHER (PLEASE LIST BELOW)
☐ DAILY ASPIRIN
☐ CORTISONE/STEROIDS
☐ ORAL CONTRACEPTIVES
☐ TRANQUILIZERS
☐ FOSAMAX / BISPHOSPHATE
☐ BLOOD PRESSURE MEDICATIONS
☐ HEART MEDICATION/DIGITALIS
☐ OSTEOPOROSIS MEDICATIONS
☐ OTHER DIABETIC MEDICATIONS

DRUG NAME	DOSAGE	REASON PRESCRIBED

Spouse or Responsible Party Information or Insurance Policy Holder

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ Insurance Policy Holder

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Employer: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative

☐ Yellow Pages ☐ Ocala Star Banner ☐ Website ☐ OTOW ☐ Radio ☐ Good Life Magazine

☐ Other _____

Name of person or office referring you to our practice: _____

Employment Information

Employer Name: _____ Occupation: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I understand I am giving my full consent to use and disclose my personal protected health information to carry out treatment, payment activities and health care operations including preparing insurance forms via the internet or mail. No information is sold for marketing purposes. I understand and have read the Notice of Privacy Practice used by Ocala Dental Care (given upon request) or am familiar with the HIPAA privacy practices required by the State of Florida. This form shall remain in effect indefinitely or until I revoke by written notice.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

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

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party