DENTAL ESTHETICS OF BOCA RATON, P.A.

851 MEADOWS RD. STE 211
BOCA RATON, FL 33486
561-395-3290

1610 N. FEDERAL HWY.
BOCA RATON, FL 33432
561-395-3290

2780 W. PALMETTO PK. RD. STE 206N
BOCA RATON, FL 33433
561-395-3290

Welcome

Yourself

Name: _____
Last First Middle (Mr. Mrs. Ms. Dr.)

Home Address: _____
Street City State Zip

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Male Female Birthdate: _____ Age: _____ SS #: _____

Single Married Divorced Widowed Separated Email: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Primary Dental Insurance Co: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group #: _____

Insured Name: _____ Relations: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

Spouse's Name: _____

Work Phone #: _____ Birthdate: _____

Spouse's Employer: _____ Spouse's SS #: _____

How did you hear about us? _____

Other Family Members Seen by Us: _____

Present/Previous Dentist: _____ Last Visit: _____

Person Responsible for Account

Name: _____

Home Phone #: _____ Work Phone #: _____ Ext: _____

Billing Address: _____

Relationship: _____ SS #: _____ Employer: _____

Emergency Contact

In the event of an emergency, whom may we contact? _____

Relationship: _____ Home Phone #: _____ Work Phone #: _____

Payment is due in full at the time of treatment unless prior arrangements have been approved. Cash, personal check, and credit cards are accepted as your treatments are provided. If you have dental insurance, we want you to receive the full benefits. Our office staff can assist you with the forms and coverage of the particular program. We accept assignment of your insurance payment. This means that you are responsible for your deductible and the portion the insurance does not cover when you see the doctor. Remember however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us. The patient will be responsible for any charges and costs incurred in the process of collecting delinquent accounts, including attorney fees, 1.75%per month will be charged to accounts over 90 days.

Signature: _____ Today's Date: _____

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Welcome

Your Medical History

Do you have a personal physician? Yes No **Are you currently under physician's care?** Yes No

Physician's Name: _____ Phone #: _____ Date of Last Visit: _____

If YES, for what reason: _____

Are you taking any prescription / over the counter drugs? Yes No

Please list ANY/ALL: _____

For Women: Are you taking contraceptives? Yes No **Are you Pregnant**? Yes No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N		Y	N	
		Heart Attack/Stroke			**Severe/Frequent Headaches**
		Heart Surgery/Pacemaker			**Asthma**
		High Blood Pressure			**Emphysema/Tuberculosis**
		Rheumatic Fever			**Shingles/Fever Blisters**
		Mitral Valve Prolapse (with regurge)			**HIV+/AIDS**
		Artificial Valves/Artificial Joints			**Venereal Diseases**
		Blood Transfusion			**Kidney Problems**
		Heart Murmur			**Hepatitis**
		Abnormal Bleeding			**Diabetes**
		Anemia			**Epilepsy/Seizures/Fainting**
		Glaucoma/Cataracts			**Psychiatric Problems**
		Cancer/Chemotherapy/Radiation Tx			**Hospitalized for any reason**

Notes: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y	N		Y	N	
		Penicillin			**Dental Anesthetics**
		Aspirin			**Latex**
		Codeine			**Other**

Please list any other drugs that you allergic to: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I understand that administration of local anesthetics may cause occasional side effects, which may include but are not limited to: bruising, cardiac stimulation, temporary or rarely permanent numbness, or muscle soreness

Signature: _____ Today's Date: _____