Welcome to Our Practice This confidential information will help us prepare for your visit.

NAME _____
Mr Mrs Ms Rev Dr
I prefer to be addressed as _____

Birthdate ___/___/___ SS# _____-____-_____

Address _____ Apt. ____

_____ Zip _____

Email_____

❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Home # _____ Work or cell # _____

Employer _____

Address _____

Occupation _____ There for ___ yrs

Where and when is best to reach you? _____

Who referred you to our office? _____

Other family members seen by us _____

Last dental visit _____

Seen by Dr. _____ for _____

****

Spouse's Name _____

Birthdate ___/___/___ Work # _____

Employer _____

Address _____

Occupation _____ There for ____yrs

****

Account Information
Name on Account ❑Self ❑Spouse ❑Other

Preferred Payment Arrangements (please check one)

❑ Cash or personal check at time of treatment

❑ Visa, MasterCard or AmEx at time of treatment

❑ I wish to establish credit with your office for personalized financial arrangements. I authorize a credit history report.

Why have you made this dental appointment?

_____

Why have you decided to leave your previous dental office?

_____

****

Please check one box in each section

❑ My mouth is very comfortable.
❑ My mouth is moderately comfortable.
❑ My mouth is uncomfortable.
❑ I think the appearance of my smile is excellent.
❑ I am satisfied with the appearance of my smile.
❑ I would like to change my smile.
❑ I am unconcerned about the appearance.
❑ I will do whatever I must to keep my teeth.
❑ I want to keep my teeth but only within a certain budget of time and money.
❑ I am indifferent about keeping my teeth.
❑ I have always done what was recommended to me.
❑ I have not done what was recommended to me.
❑ I have not had dentistry recommended to me.
❑ I put dental care high on my list for myself
❑ I put dental care low on my list.
❑ I have never considered where I put dental care.
❑ I think my present state of dental health is excellent
❑ I think my present state of dental health is good
❑ I think my present state of dental health is poor

****

Obstacles I see to excellent dental health for myself...
If you select more than one of the following please number them in order of significance with #1 being that which is most significant for you at this time.

_____ I see no obstacles

_____ Time away from work or other obligations

_____ Fear of pain, *surgery*, or injections

_____ Fear because of past dental experiences

_____ The cost of treatment

_____ Other _____

PLEASE TURN OVER AND COMPLETE THE ADDITIONAL INFORMATION ON BACK .....

My current **MEDICAL** health is:

❑ excellent ❑ good ❑ poor
Are you under the care of a physician? ❑ No ❑ Yes

Physician Name _____

Office location _____

Office telephone _____

List all medications you take (prescription and over counter)
_____

_____

_____

Have you ever had the following

❑Heart Attack	❑Heart Surgery	❑Mitral Valve Prolapse
❑Heart Murmur	❑Pacemaker	❑Rheumatic fever
❑Scarlet Fever	❑Hepatitis	❑Kidney Problems
❑Cancer	❑Chemotherapy	❑Radiation Treatment
❑HIV / Aids	❑Shingles	❑Artificial Joint
❑Fever Blisters	❑Cold Sores	❑Artificial Valve
❑Stroke	❑Sinus Trouble	❑Epilepsy / Siezures
❑Diabetes	❑Tuberculosis	❑Psychiatric Problems
❑Ulcers	❑Colitis	❑Drug/Alcohol Dependence
❑Anemia	❑Asthma	❑Hemophilia / Bleeding
❑Arthritis	❑Emphysema	❑Venereal Disease
❑Fainting	❑Glaucoma	❑Difficulty Breathing

❑Hospitalized _____
❑High / Low Blood Pressure
❑Blood Transfusion
❑Severe or Frequent Headaches _____

Have you ever taken bisphosphonate medications? _____
If yes, which ones? _____

Do you pre-medicate before dental treatment? _____

Are you Allergic to or have had difficulty with any of the following substances ....

❑Penicillin	❑Tetracycline	❑Latex
❑Aspirin	❑Codeine	❑Dental Anesthetic
❑Sulfa	❑Erythromycin	

❑Other Drugs _____

Do you exercise regularly ❑Yes ❑No
If YES what do you enjoy doing?_____
_____

For Women

Are you taking birth control pills	❑No ❑Yes
Are you pregnant	❑No ❑Yes
Are you nursing	❑No ❑Yes

The information present on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection.

SIGNED _____DATE _____

Thank you for filling this form out completely. If you have questions regarding this form or any aspect of our dental practice please call.

Brian Rask, DMD, FAGD, PA 954-782-1864

Dental Insurance Information and Agreement

Insurance Co. _____
Group # _____

As a service to our valued patients WE SUBMIT TO ALL INSURANCE COMPANY PLANS AND FILE ALL INSURANCE CLAIMS FOR YOU ELECTRONICALLY.

A SIGNED AND COMPLETED INSURANCE FORM IS REQUIRED FOR OUR FILES.

The responsibility of the insurance company is to you and it is important that you insure you are reimbursed properly. Fees for services provided to insured patients are the usual and customary fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your insurance company. The percentage of the fee paid may therefore be different than the percentage stated by your insurance company or different than the percentage listed in your benefit booklet. Dr. Rask has developed fees based on services provided and does not *participate* with insurance carriers in determining appropriate fees. In deciding whom they should participate with the doctor has selected YOU. *I wish to have you file my claims electronically. I have read the above completely and agree to the arrangements stated.*

SIGNED _____DATE _____