



Welcome

The benefits of a happy, healthy smile are immeasurable!
 Our goal is to help you reach and maintain maximum oral health.
 The better we can communicate, the better we can care for you.

ABOUT YOU

Today's Date: _____

Name: _____

I prefer to be called: _____

Male Female

Birth Date _____ Age _____ SS# _____

Home Address: _____

City _____ State _____ Zip _____

Home # _____ Wk # _____

Cell Phone # _____

Email address: _____

Single Married Divorced Separated Widowed

Employer: _____

Employer's address _____

How long there? _____

Occupation: _____

What is the best phone # to confirm your appointment at?

Whom may we thank for referring you?

Other family members seen by us:

Previous/Present Dentist: _____

Last Visit Date: _____

SPOUSE INFORMATION

His/Her Name: _____

Birth date: _____

Employer _____

Work Phone # _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

City _____ State _____ Zip _____

Insurance Co. Phone # _____

Group # (Plan, local or policy #): _____

Insured Name: _____

Insured Birth Date: _____

Insured SS# _____

Insured Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

City: _____ State _____ Zip _____

Insurance Co. Phone # _____

Group # (Plan, local or policy #): _____

Insured Name: _____

Insured Birth Date: _____

Insured SS# _____

Insured Employer: _____

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

NAME: _____

RELATIONSHIP: _____

WORK PHONE # _____

HOME PHONE # _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Billing Address _____

City _____ State _____ Zip _____

Home Phone # _____

Relationship: _____ SS# _____

Employer _____

Driver License# _____

Please continue on back

MEDICAL HISTORY

Do you have a personal physician? Yes No

PHYSICIAN'S NAME: _____ PHONE #: _____ Date of Last Visit: _____

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

For Women: Are you Pregnant/Trying to get pregnant? Yes No Taking Oral Contraceptives? Yes No Nursing? Yes

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

Do you have, or have you had, any of the following? (please check yes or no)

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/ Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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. With my informed consent, I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment. I understand that responsibility for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1% finance charge (12% annually) will be added to any balance over 90 days. In the event of default I (We) promise to pay legal interest of the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this notice.

Signature

Date

If you cannot keep an appointment please call to notify us as soon as possible. Please give us 24 hours notice so that this time may be given to another patient. If there is a cancellation with less than 24 hours notice, a broken appointment fee will be charged.

**North Pointe Dental Associates
Pross, Kanter, & Tindell, D.M.D.
801 W. Fletcher Avenue
Tampa, FL 33612
(813) 961-1727**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgment**

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for

North Pointe Dental Associates this ____ day of _____, 20___. A copy of this signed, dated Acknowledgment shall be as effective as the original.

PLEASE PRINT YOUR NAME

PLEASE SIGN YOUR NAME

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority:

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer,

Contact Person: Laura Sagar

Office Use Only	As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because: <input type="checkbox"/> It was emergency treatment. <input type="checkbox"/> I could not communicate with the patient. <input type="checkbox"/> The patient refused to sign. <input type="checkbox"/> The patient was unable to sign because: _____ <input type="checkbox"/> Other (please describe) _____ Signature of privacy officer _____
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Notice of Privacy Practices is available at any time to you. The notices includes:

- A statement that we are required by law to maintain the privacy of protected health information.
- A statement that we are required to abide by the terms of notice currently in effect.
- Types of uses and disclosures we are permitted to make for treatment, payment and health care operations.
- A description of purposes which we are permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protect health information and how I may exercise these rights

This practice reserves the right to make provisions effective for all protected health information it maintains. I understand I can obtain this practice's current Notice of Privacy Practices on request.