PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

IF THIS **APPOINTMENTIS IS FOR YOU START HERE**

DATE			1
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS **APPOINTMENT IS** FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE 2	
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

GETTING TO KNOW YOU 3		
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

ACCOUNT INFORMATION 4		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

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PLEASE TURN OVER AND SIGN

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)________________________________'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature ________________________________ Date ______________ Witness ____________________

Parent/Responsible Party's Signature ________________________________ Relationship to Patient ______________

Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? ____________________

____

Date of Last Dental Visit __________ Last Dental Cleaning __________ Last Full Mouth X-rays __________

What was done at your last dental visit? ____________________

____

Previous Dentist's Name ____________________

Address ____________________ State ______ Zip ______

Telephone ____________________

How often do you have dental examinations? ____________________

How often do you brush your teeth? __________ How often do you floss? __________

What other dental aids do you use? (Interplak, toothpick, etc.) ____________________

Do you have any dental problems now? Yes No

If yes, please describe: ____________________

Are any of your teeth senstive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? ____________________

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause ____________________

____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe ____________________

____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe ____________________

____

____

(Please complete other side)

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MEDICAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? .... Yes No
   If yes, for what? ____________
   Physician's Name ____________ Phone ____________
   Address ____________ City ____________ State ______ Zip ______
2. Have you taken any medication or drugs during the past two years? .... Yes No
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? .... Yes No
   If yes, please list name and dosage ____________
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimen (fenfluramine); and Redux (dexfenfluramine)? .... Yes No
   If yes to the above, did you have a medical exam for heart issues? .... Yes No
5. Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? .... Yes No
   If yes, please list: ____________
6. Have you been a patient in the hospital during the past five years? .... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you use more than two pillows to sleep? .... Yes No
9. Have you lost or gained more than 10 pounds in the past year? .... Yes No
10. Do you have or have you had any disease, condition, or problem not listed? .... Yes No
    If yes, please list: ____________
11. **Women:** Are you pregnant or think you may be pregnant? Yes, ____ Months No **Nursing**? Yes No
12. **Women:** Do you use birth control medications? .... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature ____________ Date ____________

History Review

Dentist Signature ____________ Date ____________

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Consent for Use and Disclosure of Health Information

Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a Revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Darshan Naidu, D.M.D
1906-H 59th Street West
Bradenton, Florida 34209
Telephone: (941) 761-9603 Fax: (941) 794-8380

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. We may decline to treat you or continue treating you if you revoke this Consent.

Emergency After Hours: In the event you require emergency attention after our hours of operation, you will be attended to by the Doctor on-call at the time. It may be Dr. Darshan Naidu D.M.D, Dr. George Burgess D.D.S or another trusted Doctor that has been arranged to take on-call duties for a specific time. The Doctor on-call will have access to your health information pertaining to giving you treatment in the event of an emergency.

Signature:
I, ________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: ________________________________ Date: ______________________

Do we have your permission to:

Mail notices to your home address Y___ N___

Leave the following information on your home answering machine/voice mail:

Appointment Information Y___ N___
Billing Information Y___ N___
Medical Information Y___ N___

Leave the following information on your work answering machine/voice mail:

Appointment Information Y___ N___
Billing Information Y___ N___
Medical Information Y___ N___

I give my permission to share appointment information with the person named below:

Name: ______________________________________

I give my permission to share medical information including biopsy and lab results with the person named below:

Name: ______________________________________

I give permission to share billing information with the person named below:

Name: ______________________________________

Signature:____ Date:___________________________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the physician, dentist, or health care provider to release to hospital or health card service plans, insurance companies, self insurers, or there representatives, any and all information and records (including x-rays) about my medical history, services rendered, or treatment given to me, that is needed to review, investigate or evaluate any claim from benefits.

If my coverage is under a group master agreement held by my employer, or association, trust fund, union or similar entity, this authorization also permits disclosure to them for purpose of utilization review or financial audit.

This authorization shall remain effective up to five years from this date.

I know that I have the right to receive a copy of the authorization if requested.

Patient's Name: ______________________________
Patient's Date Of Birth: ______________________________
Patient's Social Security Number: ______________________________

_______________ ______________________________
Date Signature of Patient or Guardian

Releasing Records To: ______________________________
____
____
____

1906-H 59th Street West, Bradenton, FL 34209 (941) 761-9603 Fax: (941) 794-8380