Comprehensive Dentistry
Airway Orthodontics
& Sleep Solutions
For Patients of All Ages

Adult Patient Information and Health History Update

We appreciate you taking the time to update your records so we can treat all of your dental needs to the best of our ability. Thank you

Patient Name: ______________________________ ____________________ _____ _____________
Last First MI Preferred Name

E Mail Address: ____

Phone: Home __________________ Mobile ____________________ Work ____________________

Address: ____

City _______________________________________ State______________ Zip__________

We communicate with our patients through phone, e-mail and texts. Which method would you prefer?
Check all that apply: ❑ Cell Phone ❑ House Phone ❑ Text Message ❑ E mail

Dental Insurance

❑ Not applicable

Subscriber's Name: _____________________________ ____________________ ____
Last First MI

Subscriber's Phone # _____________________________ Subscribers SS # ___________________________

Subscribers Birthdate:______________ ID # __________________ Group # __________________________

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: _________________________ Customer Service Phone__________________________

By signing this section, I understand that I am seeing an **OUT-OF-NETWORK PROVIDER** and I will be financially responsible for all charges not covered/denied by my insurance. I understand that Dental Partners of Vero Beach is not a Medicaid or Medicare provider and I will assume all financial responsibility for any services rendered. I authorize my insurance company to pay Dental Partners of Vero Beach all insurance benefits rendered. I authorize Dental Partners of Vero Beach to release all information necessary to secure the payment of benefits.

Signature: ____ Date: ___________________________

Medical Insurance

Dental Partners of Vero Beach provides procedures that may be covered under a patient's medical insurance. Please share your insurance information with us so we can determine if your policy would apply. Thank You

Subscriber's Name: _____________________________ ____________________ ____
Last First MI

Subscriber's Phone # _____________________________ Subscribers SS # ___________________________

Subscribers Birthdate:______________ ID # __________________ Group # __________________________

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: _________________________ Customer Service Phone__________________________

By signing this section, I understand that I am seeing an **OUT-OF-NETWORK PROVIDER** and I will be financially responsible for all charges not covered/denied by my insurance. I understand that Dental Partners of Vero Beach is not a Medicaid or Medicare provider and I will assume all financial responsibility for any services rendered. I authorize my insurance company to pay Dental Partners of Vero Beach all insurance benefits rendered. I authorize Dental Partners of Vero Beach to release all information necessary to secure the payment of benefits.

Signature: ____ Date: ___________________________

Pharmacy

Pharmacy:____ Phone#_____________________________________

Address: ____ City: ____

Primary Care Doctor

Dr. Name:____ Phone# _____________________________________

Address: ____ City: ____

Specialty:____

Date of your most recent physical exam: ______________________________

❑ Permission to forward medical findings and or discuss medical issues with your doctor. Initial _____________

Medical History Update

If you have a list of your current medications, we will be happy to make a copy for your chart.

Do you have any CURRENT HEALTH PROBLEMS? ____

What Medications, Vitamins, Herbs, Supplements are you currently taking?________________________________

____

Are you taking or have you taken BISPHOSPHONATES? Boniva, Fosamax Etc.? ❑ Yes ❑ No

Do you currently use cigars, cigarettes, pipe, or chewing tobacco? ❑ Yes ❑ No

Doctors Name: ____ Phone: _____________________________________

❑ **Permission to forward medical findings and or discuss medical issues with your doctor. Initial _____________**

Are you allergic to or have you reacted to any of the following? (Please check all that apply)

❑ Aspirin	❑ Sulfa	❑ Food Allergies	❑ Latex
❑ Metals	❑ Erythromycin	❑ Penicillin	❑ Novocain
❑ Codeine	❑ Nitrous Oxide	❑ Other _____________________________________	

Medical History

Indicate which of the following conditions you have or have had by checking the box. Check all that apply.

❑ Diabetes, list medication ____________________		❑ Non-Insulin Diabetic	❑ Insulin Dependent
❑ Blood Pressure, High	❑ Respiratory Disease	❑ Asthma	❑ COPD
❑ Blood Pressure, Low	❑ Blood Disease	❑ AIDS/HIV	❑ Shortness of Breath
❑ Mitral Valve Prolapse	❑ Hemophilia	❑ Bleeding Disorders	❑ Eating Disorder
❑ Back/Neck Issues	❑ Arthritis	❑ Glaucoma	❑ Pregnant
❑ Thyroid Disease	❑ Kidney Disease	❑ Liver Disease	❑ Acid Reflux
❑ Fainting	❑ Snore	❑ Anxiety/Nervous Problems/ Psychiatric Care	
❑ Cancer, type/when___________________________		❑ Chemotherapy	❑ Radiation
❑ Hepatitis, what type? _______________________		❑ TB	Other: ______________

❑ Artificial Joints, what type, when ____

❑ Heart Problems, please describe ____

❑ Pacemaker/Heart Surgery/ Heart Valve Replacement, what and when ________________________________

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Signature ____ Date ______________________