DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ____________________

SS/HIC/Patient ID # ____________________

Patient Name ____________________
Last Name

____
First Name Middle Initial

Address ____________________

E-mail ____________________

City ____________________

State ____________ Zip ____________

Sex ☐ M ☐ F Age ____________

Birthdate ____________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ____________________

Occupation ____________________

Employer/School Address ____________________

____

Employer/School Phone (_____) ____________________

Spouse's Name ____________________

Birthdate ____________________

SS# ____________________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________________

2 DENTAL INSURANCE

Who is responsible for this account? ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ____________________

Birthdate ____________ SS# ____________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to
Name of Insurance Company(ies)

Dr. ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient

3 PHONE NUMBERS

Phone (______) ____________ Work (______) ____________ Ext ______ Cell (______) ____________

Spouse's Work (______) ____________ Best time and place to reach you ____________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ____________________ Relationship ____________________

Home Phone (______) ____________________ Work Phone (______) ____________________

4 DENTAL HISTORY

Reason for today's visit ____________________

____

Former Dentist ____________________

City/State ____________________

Date of last dental visit ____________________

Date of last dental X-rays ____________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No
Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? ____________

How often do you brush? ____________

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5 HEALTH HISTORY

Physician's Name ______________________ Date of last visit ____________

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type ______	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date ____________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name ______________________

Phone (______) ______________________

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other ____________

____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications? __________ If so, what? ______________

Patient's Signature ______________________ Date __________

Doctor's Signature ______________________ Date __________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications? __________ If so, what? ______________

Patient's Signature ______________________ Date __________

Doctor's Signature ______________________ Date __________

LIVE LIFE SMILING

Waiver and Consent

I, ____ the undersigned, do hereby authorize to use certain photographs and/or x-rays of me taken by the office of Max Zaslavsky, DMD PA. I hereby grant them permission to reproduce, publish, print, use and distribute copies of such photographs and/or x-rays. I specifically waive any claim for invasion of my personal privacy, which might accrue to me on account of the use of such pictures without my express consent in each instance.

NO FULL FACE OR IDENTIFYING PHOTOS WILL BE USED WITHOUT YOUR EXPRESSED WRITTEN CONSENT FOR EACH ONE.

Photos taken during treatment are used by our laboratories for cosmetic purposes for the fabrication of your crowns, bridges or dentures are are a part of you permanent dental record.

____

Patient Signature Date

LIVE LIFE SMILING

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Print Full Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

( ) Individual refused to sign

( ) Communications barriers prohibited us from obtaining acknowledgment

( ) An emergency situation prevented us from obtaining acknowledgment

( ) Other (Please Specify)

____
____
____
____
____

OFFICE POLICIES FOR DR. MAX ZASLAVSKY

Confirmation Calls / Late Arrivals / Broken Appointments

- We call to confirm appointments two days prior to your appointment date. If you have not heard from us, it will be your responsibility to call to confirm your dental appointment. We understand everyone has a busy schedule or cannot talk on the phone while at work, please call us even after business hours and leave a message. Any appointment not confirmed by 4pm the day prior to your appointment, will be cancelled.
- Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrival will be worked into the schedule if time allows or re-appointed to another day.
- Since appointment times are reserved exclusively for each patient, we ask that you please notify our office at least 24 hour in advance of your appointment time if you are unable to make it. If you cancel you appointment less than 24 hours in advance, you will be charged a broken appointment fee of $75.00.

Deposits

- Due to the recent number of missed appointments, our office is now taking a $75.00 deposit for any appointment that is one hour long. ($75.00 for every hour you are scheduled for)

Payments

- Payment for all services is due at the time of your appointment. Our front office staff is committed to guiding you in choosing the best payment option to meet your financial needs. If you are unable to make payment at the time of your appointment, it may be necessary to reschedule your appointment for a time in which payment will be more comfortable for you. Our office accepts: Cash, VISA, MC, American Express, Discover and Care Credit

Dental Insurance

- You dental insurance is a contract between you and your insurance company. We are not a party to that contract. Our experienced staff will do everything possible to make the most of the insurance benefits to which you are entitled. However, some and, perhaps all of the services provided to you may be non-covered services and considered not necessary under your insurance policy. You are ultimately responsible for all expenses incurred regardless of your insurance benefits. If we are provided with correct policy information and are able to verify your dental benefits, an estimate of your initial responsibility (Co-Payment) will be determined. This estimate is based on several factors including but not limited to deductible, maximum, co-insurance, frequency limitations, waiting periods, coordination of benefits and usual and customary rates. This estimate is NOT a guarantee of insurance company's payment. Your final responsibility can only be determined after your dental claim has been paid. If there is a remaining balance after your insurance has made payment, it will then be billed to you. If you have any question regarding the billing process, we suggest that you contact your insurance company directly. We file insurance claims as a courtesy to our patients, but your claim is still your responsibility if your insurance company has not paid your claim within 60 days, the balance will be automatically billed to you.

Account Collections

- If it becomes necessary to seek a collection agency to receive payment from you, your account will be charged a fee of $25, It will be your responsibility for any cost for any costs related to the collection of your account.

Records

- If for any reason you decide to leave our practice, we understand you have the right to request copies of your dental records/x-rays. There will be a $25 fee for a copy of your records/x-rays. We are licensed by the Florida Board of Radiology to take x-rays and are required by law to retain originals on file.

Patient Name: ______________________________

Patient Signature: ______________________________ Date: ________________

Max Zaslavsky, DMD, PA

HIPPA CONSENT FORM

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Department of Health and Human Services has established a "Privacy rule" to help insure that personal health care information is protected for privacy. The rule also created in order to provide a standard for certain health care provider to obtain to patients consent for uses and disclosure for health information about the patient to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect your privacy and strictly enforce the rules. Furthermore, you may refuse to consent the use of disclosure of your health information however, this must be in writing. Under the law we have the right to refuse to treat you.

I, ____, understand the above; and/or have read a copy of the Florida Department of Health notice of privacy practices which this dental office **STRICTLY FOLLOWS.**

I, hereby authorize Dr. Max Zaslavasky to share this information with my Spouse or Parent____.

______________________________ ______________________________

(Print Name of Responsible Party) (Print Patient Name)

______________________________ ______________________________

(Signature of Responsible Party) (Date)

STAFF MEMBER INITIALS: ______________

______________**For Office Use Only**______________

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but could not be obtained because:

_____ Patient refused to sign consent form.
_____ Communication barriers prohibited obtaining acknowledgement.
_____ A emergency situation prevented us from obtaining acknowledgement.
_____ Other (Please Specify) ______________________________________