

# Welcome

We are pleased to welcome you to our practice.  
Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

## Patient Information

Date \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ SS/HIC/Patient ID # \_\_\_\_\_  
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 (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## Primary Insurance

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered under this plan \_\_\_\_\_

## Authorization

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

**Michael J. Fernandez, D.M.D., P.A.** 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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.



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**MEDICAL HISTORY**

Name \_\_\_\_\_

Date \_\_\_\_\_

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 list on back of page \_\_\_\_\_

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

Women: Are you

Pregnant/Trying to get pregnant?  Nursing

Taking oral contraceptives?

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?

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Yellow Jaundice            |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever       |   |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism            |   |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Shingles              |   |

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

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What is your current dental problem (if any)? \_\_\_\_\_

Are you in pain? \_\_\_\_\_ Do you desire to maintain your own teeth and gums? \_\_\_\_\_

Have you ever had a bad experience in a dental office? \_\_\_\_\_

To the best of my knowledge, the questions on this form has been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# RECORDS RELEASE/REQUEST

To \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I hereby authorize the release of my \_\_\_\_\_

or copies of such and request that they be transferred to and /or delivered to the patient, a patient

Representative, and/or another provider.

\_\_\_\_\_  
Print Name of Patient date of birth

\_\_\_\_\_  
Patient's Signature Date

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\* You May Refuse to Sign This Acknowledgement\*

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

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_