DREAM TEAM
DENTISTRY

17178 Toledo Blade Blvd
Port Charlotte, FL 33954
Tel: 941-625-7877

PATIENT REGISTRATION

So we may provide you with the best possible care and get to know you better, please complete these personal information, medical & dental history forms. All information is confidential.

Today's Date: _____ Preferred Name: _____

Legal Name: First: _____ Last: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Work: _____ Email: _____

Date of Birth: _____/_____/_____ Social Security #: _____ Sex: M F

Marital Status: _____ Whom may we thank for referring you? _____

Physician's name: _____ Phone #: _____

Emergency Contact: _____ Phone #_____

RESPONSIBLE PARTY/DENTAL INSURANCE

Person Responsible for Account (if different from the patient): _____

Relationship to Patient: _____ Date of Birth____/____/_____ SS#:_____

Address (If different from patient): _____

City: _____ State: _____ Zip: _____ Phone #: _____

Subscriber's Employer: _____ Work Phone #: _____

Insurance Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Consent for Treatment

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent of guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Patient Signature: _____ Date: _____

(Parent or Guardian must sign IF patient is under 18)

MEDICAL HISTORY

This questionnaire will be used by your dentist to help treat you safely. Please answer all questions as accurately as possible.

Do you have or have you had any of the following? (Please circle one)

Aids/HIV	Y / N	Hepatitis/Jaundice	Y / N
Allergy to Latex	Y / N	High Blood Pressure	Y / N
Anemia	Y / N	Irregular Heart Beat	Y / N
Chest Pain	Y / N	Kidney Disease	Y / N
Arthritis	Y / N	Liver Disease	Y / N
Artificial Joints	Y / N	Mitral Valve Prolapse	Y / N
Asthma	Y / N	Organ Transplant	Y / N
Bleeding disorder	Y / N	Pacemaker/Defibrillator	Y / N
Cancer	Y / N	Artificial Heart Valve	Y / N
Chemotherapy	Y / N	Psychiatric Treatment	Y / N
Colitis/Intestinal	Y / N	Radiation Therapy	Y / N
Diabetes	Y / N	Renal Dialysis	Y / N
Emphysema	Y / N	Rheumatic Fever	Y / N
Epilepsy/Seizure	Y / N	Sexually Transmitted Disease	Y / N
Heart Attack	Y / N	Stomach Ulcer	Y / N
Heart Disease	Y / N	Stroke	Y / N
Heart/Bypass Surgery	Y / N	Thyroid Disease	Y / N
Heart Murmur	Y / N	Tuberculosis	Y / N
Pre-medicate before appts?	**Y / N**	**Blood Thinners/Aspirin**	Y / N

Do you smoke tobacco? Y / N How much do you smoke? _____ How Long? _____

Do you use alcohol? Y / N How Many per week? _____ Recreational Drugs? Y / N

Are you pregnant? Y / N How many weeks? _____ Are you taking birth control? Y / N

Please List Any Allergies: _____

_____

Please List Any Medications: _____

_____

_____

DENTAL HISTORY & SMILE ANALYSIS

When was your last dental appointment? _____

Are you having any problems at this time? _____

Have you ever been treated or told that you have gum disease? Y / N

On a scale from 1-10 how would you rate your: Dental Health: _____ Your Smile: _____

Is there anything that concerns you about your smile? (Color, spaces, chips, old crowns/fillings, etc.) Y / N

If yes, how would you like to see your smile change? _____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Dream Team Dentistry this _____ day of _____, 20_____. A copy of this signed, dated Acknowledgement 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 and describe your authority:

_____ _____

I give permission for Dream Team Dentistry to disclose billing, appointment and/or treatment information to:

_____ _____ _____

FINANCIAL POLICY

We appreciate the opportunity to serve you! We've found that a clear understanding of our financial policy in advance of dental care helps to relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you might have. We will do our best to answer them for you.

- **Patients without insurance coverage need to know:** The fee for treatment rendered must be paid in full on the day of service.
- **We accept Visa, MasterCard, Discover, American Express, Cash and Checks for payment of the amount due.** Payment plans are available through **Care Credit**. Please NOTE: There is a fee (currently $35) for any check returned by the bank.
- **We do require two business days' notice for all cancellations. Appointments not cancelled within 2 business days are subject to a charge of $50 per hour of reserved appointment time.**

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection to the balance of a lawyer, you agree to pay all lawyers' fees that we incur plus all court costs.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency or we have to litigate in court, your past due status is reported to a credit reporting agency and the fact that you received treatment at our office may become public record.

Insurance: Insurance is a contract between you and your insurance company. We will file claims to your insurance as a courtesy to you. Please note that services are not rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment of all fees generated by your treatment. If your insurance company has not paid your claim within 90 days after the date of service, the full amount is due and payable by you. We will promptly refund you any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance company.

This financial policy is an agreement between Dream Team Dentistry, as creditor, and the Patient/Debtor named on this form. By executing this agreement, you consent to treatment by Dr. Bates, Dr. Matheny and their team and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in effect.

Patient Signature: _____ Date: _____

(Parent or Guardian must sign IF patient is under 18)