JAX BEACHES
FAMILY DENTISTRY

Complete Health Dentistry
Same-day Crowns & Veneers
Dental Implants
Emergency Care
Extended Hours

PATIENT INFORMATION

Patient Name _____ Today's Date _____

Date of Birth _____ Age _____ ☐ Male ☐ Female

SS# _____ DL# _____

Home address _____

Phone: Home _____ Work _____ Mobile _____

Email _____

Occupation _____

Parent/Guardian name (if patient is a minor) _____ Date of Birth _____

Emergency Contact _____ Contact Phone _____

DENTAL INSURANCE INFORMATION

Will you be utilizing dental insurance for your visit? ☐ Yes ☐ No

How important it is to you for your insurance to help with your dental treatment?

☐ Very important ☐ Mildly important ☐ Not important

PRIMARY INSURANCE

Name of Insurance Company _____ Phone _____

Policy Holder Name _____ Relationship to Patient _____

Policy Holder Date of Birth _____ Employer _____

Policy/Member ID _____ Group # _____

SECONDARY INSURANCE

☐ Yes ☐ No If yes, please present card.

PATIENT REFERRALS are the highest compliment we can receive.

Whom may we thank for referring you to our practice? _____

How did you hear about our office? ☐ Social media ☐ Billboard ☐ Internet search ☐ Referral _____

☐ TV ☐ Radio ☐ Brochure ☐ Mailing ☐ Other _____

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REVIEW OF SYMPTOMS - MEDICAL / DENTAL - Please mark any current or past conditions:

Family History
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Other _____

Blood/Lymphatic
- ☐ Anemia
- ☐ Blood disease
- ☐ Easy bruising/bleeding
- ☐ Blood pressure: high/low
- ☐ Blood thinner
- ☐ Blood transfusion
- ☐ Diabetes Type_____
- ☐ Gout
- ☐ Hemophilia
- ☐ Hepatitis A, B or C
- ☐ History of blood clots
- ☐ History of low/high platelets
- ☐ History of low WBC
- ☐ HIV-AIDS
- ☐ Hypoglycemia
- ☐ Leukemia
- ☐ Rheumatism
- ☐ Sickle cell disease
- ☐ Thyroid disease
- ☐ Unusual bleeding
- ☐ Yellow jaundice

Cancer
Type _____
- ☐ Chemotherapy
- ☐ Radiation therapy

Muscle/Skeletal
- ☐ Artificial joint _____
- ☐ Arthritis
- ☐ Back/neck/spine problems
- ☐ History of bone fractures
- ☐ History of torn/ruptured tendons
- ☐ Joint problems
- ☐ Muscle injury
- ☐ Muscle side effects from statins
- ☐ Osteoporosis
- ☐ Pain in jaw joints
- ☐ Paralysis of any muscle
- ☐ Unusual muscle weakness

Cardiovascular
- ☐ Artificial heart valve
- ☐ Congenital heart disorder
- ☐ Chest pain (angina)
- ☐ Heart attack/failure
- ☐ Heart disease
- ☐ Heart murmur
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Mitral value prolapse
- ☐ Pacemaker
- ☐ Stroke
- ☐ Swelling in feet or legs
- ☐ Varicose veins

Constitutional (fever/chills/sweats):
- ☐ Brittle nails
- ☐ Change in skin/hair texture
- ☐ Change in energy/increased weakness
- ☐ Dry skin
- ☐ Excessive thirst or urination
- ☐ Inability to stand heat/cold
- ☐ Unexplained weight loss/gain

Eyes
- ☐ Cataracts (date of surgery)_____
- ☐ Dry eyes
- ☐ Double vision
- ☐ Glaucoma
- ☐ History of retinal tear or hemorrhages

Genitourinary
- ☐ Blood in urine
- ☐ Kidney disease
- ☐ Renal dialysis
- ☐ Unusual frequency of urination
- ☐ Urination that interrupts sleep
- ☐ Venereal disease

Skin
- ☐ Cold sores/fever blisters
- ☐ Frequent itching of skin
- ☐ Herpes/shingles
- ☐ Hives/rash
- ☐ Skin infections
- ☐ Tumors/growths

Gastrointestinal
- ☐ Abdominal pain
- ☐ Acid reflux
- ☐ Blood in bowel
- ☐ Diarrhea/constipation
- ☐ Heartburn/nausea
- ☐ Loss of appetite
- ☐ Stomach/intestinal disease
- ☐ Ulcers
- ☐ Weight loss/gain

Neurological
- ☐ Alzheimer's
- ☐ Epilepsy or seizures
- ☐ Fainting/dizziness/convulsions
- ☐ Headaches
- ☐ Light-headedness
- ☐ Loss of coordination
- ☐ Memory loss
- ☐ Tingling, pain, numbness in hands or feet

Psychiatric
- ☐ Anxiety
- ☐ Anger issues
- ☐ Depression
- ☐ Drug addiction
- ☐ Mania
- ☐ Panic attacks
- ☐ Problems with sleep
- ☐ Psychiatric care
- ☐ PTSD
- ☐ Suicidal thoughts
- ☐ Short temper or impatience

Respiratory
- ☐ Anaphylaxis
- ☐ Asthma
- ☐ COPD
- ☐ Cough/wheeze
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Frequent respiratory infections
- ☐ Hay fever
- ☐ Lung disease
- ☐ Sinus trouble
- ☐ Sleep apnea/CPAP
- ☐ Snoring

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Complete Health, Medical & Dental History

Patient Name _____ Today's Date _____

A healthy body starts with a healthy mouth. Although dental professionals primarily treat the area in and around your mouth, it is part of your entire body. Health and medication could have an important relationship with your dentistry. Thank you for answering the following questions accurately.

MEDICAL HISTORY

Name of physician _____ Date of last physical exam _____

Medication

Please list all medications you are currently taking (prescription & non-prescription) _____

_____

Are you allergic to any of the following: ☐ No Allergies

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Sulfa Drugs ☐ Other _____

Have you been hospitalized or had a major operation? ☐ Yes ☐ No Please explain _____

Have you had a serious head or neck injury? ☐ Yes ☐ No Please explain _____

Do you currently or have you ever taken medication for bone loss (Fosomax, Boniva) ☐ Yes ☐ No

Do you premedicate for dental appointments? ☐ Yes ☐ No Please explain _____

Females

Are you pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

ORAL HEALTH

Name of previous dentist: _____ Date of last cleaning _____ Xrays _____

How important is your dental and oral health to you? **(important) 1 2 3 4 5 (not important)**

List current problems or concerns _____

How many times per day do you brush? _____ How many times per week do you floss? _____

Type of toothbrush: ☐ Rotary ☐ Hard ☐ Medium ☐ Soft Do your gums ever bleed? ☐ Yes ☐ No

Have you had periodontal (gum) treatment? ☐ Yes ☐ No If yes, when? _____

WOULD YOU BE INTERESTED IN ANY OF THE FOLLOWING?

☐ Straighter teeth with clear aligner therapy
☐ Whiter teeth
☐ Reduction in snoring
☐ Non-surgical gum therapy
☐ Facial cosmetics
☐ Oral appliances for sleep apnea

SLEEP

Use the scale to select the most appropriate number for each situation.
Total the numbers at the bottom for your total score.

0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

Epworth Sleepiness Scale

0-5	normal daytime sleepiness
6-10	mild apnea risk
11-15	moderate apnea risk
16-24	severe apnea risk

SITUATION	CHANCE OF DOZING (never)			(high)
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Sitting as passenger in vehicle for an hour	0	1	2	3
In a vehicle and stopped for a few minutes	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (no alcohol)	0	1	2	3
Total each column	____ +	____ +	____ +	____ = **TOTAL SCORE** ____ /24

STRESS

How would you classify your stress level at work? (check one) ☐ Low ☐ Medium ☐ High

How would you classify your stress level at home? ☐ Low ☐ Medium ☐ High

How do you manage stress? _____

Do you feel safe in your environment (home/work)? ☐ Yes ☐ No If yes/no, why? _____

SOCIAL HISTORY

Tobacco

Cigarettes: ☐ Never ☐ Quit; year quit _____ ☐ Current smoker; packs per day _____

Other tobacco (mark all that apply)

☐ Pipe ☐ Cigar ☐ Chewing tobacco ☐ e-cigarettes ☐ Marijuana

Number of years of tobacco use? _____ Are you interested in quitting? _____

Alcohol

Do you drink alcohol? ☐ Yes ☐ No Type(s): _____

If yes, how many drinks to you consume per week? _____

Does your alcohol consumption have you or others concerned? ☐ Yes ☐ No

Caffeine

Coffee _____ cups/day Tea _____ cups/day Sodas per day _____ ☐ Diet ☐ Regular

Chocolate _____ ounces/day ☐ Dark ☐ Light

Do you drink energy drinks or take pills to stay awake? ☐ Yes ☐ No If yes, specify _____

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No How often? _____

What type(s) _____

If you do not exercise, why not? _____

Do you have limitations to your ability to exercise? _____ Please explain _____

Acknowledgement of Receipt of Notice of Privacy Policies (Adult)

Your privacy is important to us. We will discuss your treatment recommendation and account with members on the same account unless otherwise specified.

I have received a copy of the Notice of Privacy Practices of Jax Beach Family Dentistry. I hereby authorize (as indicated by my signature below) Jax Beach Family Dentistry to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Patient Name (print) _____

Address _____

Signature _____ Date _____

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at _____

☐ You may text me at _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added/Removed _____

2. _____ Date Added/Removed _____

For Office Use Only
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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (specify) _____

Staff Person Initials _____

RESERVED APPOINTMENT AGREEMENT

An appointment time has been reserved for you. We schedule an appropriate amount of time for your treatment and take pride in staying on schedule, resulting in unnecessary wait time. We want you to know that we value and honor your time. If you are unable to keep your scheduled appointment, please call 48 hours in advance so that we may reschedule you at a more convenient time. **If you fail to provide 48 hours' notice, a deposit will be required to reschedule. A 50% deposit will be required for treatment appointments scheduled with the doctor.**

If you know that you will be arriving 5 or more minutes late, please call before you arrive. This way, if it becomes necessary to reschedule your appointment, you will have avoided a hurried trip to the office and make it possible for us to give that time to a patient who is waiting on our VIP list.

FINANCIAL POLICY

As a courtesy to you, Jax Beaches Family Dentistry will file claims to your dental insurance for services rendered. We will provide you with an insurance **ESTIMATE** for dental treatment based on non-contracted provider benefits. **THIS IS NOT A GUARANTEE YOUR INSURANCE WILL PAY EXACTLY AS ESTIMATED.** Your insurance company and your plan benefits ultimately determine the amount paid. All charges incurred are your responsibility regardless of insurance coverage. Upon request, we will file a pre-determination of benefits which can take 30 days and may require x-rays.

FINANCIAL AGREEMENT

This agreement authorizes Jax Beaches Family Dentistry to file claims to my dental insurance company for services rendered. I authorize my insurance company to pay all benefits for services rendered directly to Jax Beaches Family Dentistry. If the insurance company sends payment directly to me, it is my responsibility to forward that payment to Jax Beaches Family Dentistry.

_____ **(patient initials) I understand that the dental providers at Jax Beaches Family Dentistry are not contracted with my insurance company and the polices out of network benefits will be utilized.** All deductibles and estimated co-insurance is due when services are rendered unless prior arrangements have been made. I understand and agree to Jax Beaches Family Dentistry's policies and agreements.

Patient Name _____

Signature _____

Date _____

JAX BEACHES
FAMILY DENTISTRY

COVID-19 PANDEMIC EMERGENCY/ELECTIVE DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office and with dental treatment. I further confirm I am seeing treatment for a condition that meets the criteria above. I understand and accept the additional risk of contracting COVID-19 from contact with this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

Patient Name (PRINTED)	Patient Signature
Date	Witness