Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- We will be happy to help.

Patient Information (CONFIDENTIAL)

Date: _____

Name _____ *Birthdate* _____

Address _____ *City* _____ *State* ____ *Zip* _____

Home Phone _____ *Cell Phone* _____ *Business* _____

Email _____

Check Appropriate Box: □*Minor* □*Single* □*Married* □*Divorced* □*Widowed* □*Separated*

If student, Name of School/College _____ *City* _____ *State* ____ □*Full/*□*Part-time*

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ *Phone* _____

Responsible Party

Name of Person Responsible for this Account / Relationship to patient _____

Address _____ *Home Phone* _____

Email _____ *Cell Phone* _____

Driver's License # _____ *Birthdate* _____ *SSN#/SIN* _____

Is this Person Currently a Patient in our Office? □ *Yes* □*No*

For your convenience, we offer the following methods of payment. Please check the option you prefer.

□ *Cash* □ *Personal Check* □ *AmEx* □ *VISA* □ *MasterCard* □ *CareCredit* □ *Chase*

Insurance Information

Name of Insured / Relationship to patient _____

Birthdate _____ *SSN#/SIN* _____ *Date Employed* _____

Name of Employer _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* ____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID #* _____

Do you have additional insurance? □ *Yes* □ *No* *If YES, Complete the following:*

Name of Insured / Relationship to patient _____

Birthdate _____ *SSN#/SIN* _____ *Date Employed* _____

Name of Employer _____ *Work Phone* _____

Address of Employer _____ *City* _____ *State* ____ *Zip* _____

Insurance Company _____ *Group #* _____ *Policy/ID #* _____

Patient Medical History

Physician _____ *Office Phone* _____ *Last Exam* _____

1. Are you under medical treatment now?
□ *Yes* □ *No*

2. Have you ever been hospitalized for any surgical operation or illness within the last 5 years?
□ *Yes* □ *No*

3. Are you taking any medication (s) including non-prescription medicine?
□ *Yes* □ *No*
If yes, what medication (s) are you taking? _____

4. Do you use tobacco?
□ *Yes* □ *No*

5. Do you use controlled substances?
□ *Yes* □ *No*

6. Do you have a persistent cough or throat clearing not associated with a known illness (lasting 3+ weeks)
□ *Yes* □ *No*

7. ***Are you allergic or have you had any reactions to the following?***

Local Anesthetics (e.g. Novocain)	□ *Yes*	□ *No*
Penicillin or any other Antibiotics	□ *Yes*	□ *No*
Sulfa Drugs	□ *Yes*	□ *No*
Barbiturates	□ *Yes*	□ *No*
Sedatives	□ *Yes*	□ *No*
Iodine	□ *Yes*	□ *No*
Aspirin	□ *Yes*	□ *No*
Any Metals (e.g. nickel, mercury, etc)	□ *Yes*	□ *No*
Latex Rubber	□ *Yes*	□ *No*
Other (please list)	□ *Yes*	□ *No*

8. ***Do you have or have you had any of the following?***

High Blood Pressure	□ *Yes*	□ *No*	*Arthritis*	□ *Yes*	□ *No*
Low Blood Pressure	□ *Yes*	□ *No*	*Joint Replacement or Implant*	□ *Yes*	□ *No*
Heart Attack	□ *Yes*	□ *No*	*AIDS or HIV Infection*	□ *Yes*	□ *No*
Heart Disease	□ *Yes*	□ *No*	*Sexually Transmitted Disease*	□ *Yes*	□ *No*
Cardiac Pacemaker	□ *Yes*	□ *No*	*Cancer*	□ *Yes*	□ *No*
Heart Murmur	□ *Yes*	□ *No*	*Leukemia*	□ *Yes*	□ *No*
Angina	□ *Yes*	□ *No*	*Radiation Therapy*	□ *Yes*	□ *No*
Mitral Valve Prolapse	□ *Yes*	□ *No*	*Chemotherapy*	□ *Yes*	□ *No*
Chest Pains	□ *Yes*	□ *No*	*Epilepsy / Convulsions*	□ *Yes*	□ *No*
Stroke	□ *Yes*	□ *No*	*Fainting / Seizures*	□ *Yes*	□ *No*
Liver Disease	□ *Yes*	□ *No*	*Anemia*	□ *Yes*	□ *No*
Hepatitis / Jaundice	□ *Yes*	□ *No*	*Frequently Fatigued*	□ *Yes*	□ *No*
Kidney Diseases	□ *Yes*	□ *No*	*Excessive Bleeding*	□ *Yes*	□ *No*
Asthma	□ *Yes*	□ *No*	*Blood Transfusion*	□ *Yes*	□ *No*
Emphysema	□ *Yes*	□ *No*	*Sinus Problems*	□ *Yes*	□ *No*
Respiratory Problems	□ *Yes*	□ *No*	*Measles*	□ *Yes*	□ *No*
Hay Fever / Allergies	□ *Yes*	□ *No*	*Mumps*	□ *Yes*	□ *No*
Diabetes	□ *Yes*	□ *No*	*Nervous Disorder*	□ *Yes*	□ *No*
Thyroid Problems	□ *Yes*	□ *No*	*Psychiatric Care*	□ *Yes*	□ *No*
Tuberculosis	□ *Yes*	□ *No*	*Glaucoma*	□ *Yes*	□ *No*
Stomach Troubles / Ulcers	□ *Yes*	□ *No*	*Other* _____		

Patient Medical History (Continued)

9. Women Only:

a) Are you pregnant or think you may be pregnant?
□ *Yes* □ *No*

b) Are you nursing?
□ *Yes* □ *No*

c) Are you taking oral contraceptives?
□ *Yes* □ *No*

Patient Dental History

Name of Previous Dentist and Location _____ *Last Exam* _____

1. Do your gums bleed while brushing or flossing?	□ *Yes*	□ *No*
2. Are your teeth sensitive to hot or cold liquids/foods?	□ *Yes*	□ *No*
3. Are your teeth sensitive to sweet or sour liquids/foods?	□ *Yes*	□ *No*
4. Do you feel pain to any of your teeth?	□ *Yes*	□ *No*
5. Do you have any sore or lumps in or near your mouth?	□ *Yes*	□ *No*
6. Have you had any head, neck, or jaw injuries?	□ *Yes*	□ *No*
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	□ *Yes*	□ *No*
Pain (joint, ear, side of face)	□ *Yes*	□ *No*
Difficulty in opening or closing	□ *Yes*	□ *No*
Difficulty chewing?	□ *Yes*	□ *No*
8. Do you have frequent headaches?	□ *Yes*	□ *No*
9. Do you clench or grind your teeth?	□ *Yes*	□ *No*
10. Do you bite your lips or cheeks frequently?	□ *Yes*	□ *No*
11. Have you ever had any difficult extractions in the past?	□ *Yes*	□ *No*
12. Have you ever had any prolonged bleeding following extractions?	□ *Yes*	□ *No*
13. Have you ever had any orthodontic treatment?	□ *Yes*	□ *No*
14. Do you wear dentures or partials?	□ *Yes*	□ *No*
15. Do you like your smile?	□ *Yes*	□ *No*

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Parent _____

Doctor's Comments _____

_____

Signature _____ ***Date*** _____

Heron Bay Dental Associates, P.A.
Keith M. Friefeld, D.D.S.
5960 Coral Ridge Drive
Coral Springs, Fl 33076
954-255-5550

Cancellation or Missed Appointment Policy

PLEASE READ, SIGN, AND DATE

EFFECTIVE IMMEDIATELY

Because of the high volume of missed and/or cancelled appointments, the office will charge a fee of $25.00 for any appointment cancelled or missed without a 24 hour notice.

I have read and fully understand the above office cancellation and/or missed appointment policy and I am aware of the fee for no show and/or missed appointments.

Signature_____

Date_____

HERON BAY DENTAL ASSOCIATES, P.A.

5960 Coral Ridge Drive • Coral Springs, FL 33076

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have reviewed/received a copy of
Patient Name

HERON BAY DENTAL ASSOCIATES, P.A. 's Notice of Privacy Practices.
Practice Name

_____ _____
Signature of Patient / Guardian Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: