7599 Park Blvd N, Suite #200 | Pinellas Park, FL 33781 | 727-999-2075 | www.healthnowdental.com
1180 Ponce De Leon, #801B | Clearwater, FL 33756 | 727-517-9599 | www.healthnowdentalbelleair.com

Patient Registration

Name: _____ Title: _____

Preferred Name: _____ Gender: _____ Family Status: Married, Single, Child

DOB: _____ SS#: _____ Email Address: _____

Home P: _____ Work: _____ Cell:_____ Best # to call: _____

Address: _____City:_____State:_____ Zip:_____

Employer Name: _____ Phone: _____

Address: _____City:_____State:_____ Zip:_____

Occupation: _____

Physician: _____

Phone #: _____

Personal Responsible for Account if Minor

Name of Parent/Guardian: _____

Parent/Guardian's SS#: _____

Parent/Guardian's Birth date: _____

Parent/Guardian's Employer:_____

Employer's Address: _____

_____

Dental Insurance Information

Insured's Name:_____

DOB: _____ SS#: _____

Relationship to pt: _____

Insured's Employer:_____

Ins. Co. Name: _____

Ins. Co. Address: _____

_____

Phone#: _____

ID#: _____

Group#: _____

Who may we thank for referring you to our office?

_____

What would you like to accomplish with today's visit? _____

Previous Dentist: _____

How long since your last dental visit? _____

Health History

Indicate which of the following you have or have had by circling **Yes** or **No**.

Pre-Med Amox	Y	N	Pre-Med-Clind	Y	N	Pre-Med Other	Y	N
Allergies	Y	N	Allergy-Aspirin	Y	N	Allergy-Codeine	Y	N
Allergy-Erythro	Y	N	Allergy-Hay Fever	Y	N	Allergy-Latex	Y	N
Allergy-Other	Y	N	Allergy-Penicillin	Y	N	Allergy-Sulfa	Y	N
Anemia	Y	N	Arthritis	Y	N	Bisphosphonates	Y	N
Artificial Joints	Y	N	Asthma/Emphysema	Y	N	Cancer	Y	N
Blood Disease	Y	N	Blood Thinners	Y	N	Dizziness	Y	N
Chemotherapy Tx	Y	N	Diabetes	Y	N	Excessive Bleeding	Y	N
Drug Addiction	Y	N	Epilepsy/Seizures	Y	N	Fever Blisters	Y	N
Fainting	Y	N	Glaucoma	Y	N	Head Injuries	Y	N
Heart Disease	Y	N	Heart Murmur	Y	N	Heart/Valve Surgery	Y	N
Hepatitis	Y	N	High Blood Pressure	Y	N	HIV	Y	N
Jaundice	Y	N	Kidney Disease	Y	N	Liver Disease	Y	N
Lupus	Y	N	Mental Disorders	Y	N	Nervous Disorders	Y	N
Other	Y	N	Pacemaker	Y	N	Radiation Treatment	Y	N
Respiratory Problems	Y	N	Rheumatic Fever	Y	N	Rheumatism	Y	N
Sinus Problems	Y	N	Stomach Problems	Y	N	Stroke	Y	N
Thyroid	Y	N	TMJ	Y	N	Tobacco Products	Y	N
Tuberculosis	Y	N	Tumors	Y	N	Ulcers	Y	N

Are you pregnant? Y N If yes, what month? _____ Are you nursing? Y N

List ALL medications and herbal supplements: _____

_____

Have you been given or have you taken any of the following medications: Please circle

Fosamax (Alendronate) Acetonel/Atelvia (Risedronate) Boniva (Ibandronate)

Bonefos/Clasteon (Clodronate) Aredia (Pamidronate) Reclast/Zometa (Zoledronic Acid)

Do you have any heart conditions or joint replacements that require premedication? _____

Any other conditions we should aware of? _____

We understand that a situation may arise that could force you to postpone your treatment. Please understand that such changes affect not only your dentist but our ability to help other patients. Doctor's time as well as that of our staff, is a precious commodity and we request our courtesy and respect. A $50 administrative fee will be charged to patients who habitually change or cancel their appointments within 48 hours of their scheduled visit.
I understand that all responsibility for payment of dental services provide in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I further understand that a collection fees may be added to overdue balances.
I authorize release of any information for insurance, medical or dental purposes.
I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

Signature: _____ Date: _____
Patient/Guardian

Signature: _____ Date: _____
Doctor