Dr. Julia German, DMD
5481 SW 60th St, #202 Ocala FL 34474
(352) 653-3161
www.OcalaDentalDiscovery.com

WELCOME TO DENTAL DISCOVERY

Patient Information

First Name	*Last Name*	*Middle Initial*
Home Address	*City*	*State* *Zip*
Home Phone	*Cell Phone*	*Work Phone*
Social Security Number	*Date of Birth*	*Email*
Emergency Contact Name	*Phone Number*	

Insurance Policy Holder / Responsible Party Information

Name (If other than patient name)		*Relationship to Patient*
Home Address	*City*	*State* *Zip*
Home Phone	*Cell Phone*	*Work Phone*
Social Security Number	*Date of Birth*	*Employer Name*
Insurance Company	*Phone Number*	*Group or Policy Number*

Dental Information

Why are you here today?	
Previous Dentist Name	*Reason for leaving*
Are you in any discomfort today? *Please Describe:*	

Does Dental Treatment make you nervous?	□ Yes	□ No
Do you have bleeding gums?	□ Yes	□ No
Do you have difficulty brushing your teeth?	□ Yes	□ No
Do you have bad breath?	□ Yes	□ No
Do you grind your teeth?	□ Yes	□ No
Are you sensitive to cold, hot, sweets?	□ Yes	□ No
Do you use tobacco?	□ Yes	□ No
Do you have well water?	□ Yes	□ No
Are you taking any fluoride supplements or use fluoride mouth rinse	□ Yes	□ No
Do you drink coffee or tea	□ Yes	□ No

Are you satisfied with your oral health? *If not, please describe what would you change:*	□ Yes	□ No
When you look in the mirror, do you like the smile you see? *If not, please describe what bothers you?*	□ Yes	□ No

Medical Alert

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MEDICAL HISTORY

Name:
Chart #:

Dear patient,

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Therefore, health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a care of a physician?	□ Yes	□ No	Name:	Phone:
Have you ever been hospitalized?	□ Yes	□ No	Describe:	
Have you ever had head or neck injury?	□ Yes	□ No	Describe:	
Have you taken Phen-Fen or Redux?	□ Yes	□ No		
Do you use tobacco?	□ Yes	□ No	How much?	
Do you use controlled substances?	□ Yes	□ No	Describe:	
Are you pregnant?	□ Yes	□ No	Nursing? □ Yes □ No	
Are you taking oral contraceptive?	□ Yes	□ No		

In the spaces below, please list all medications, pills, or drugs you are presently taking:

Medication	Prescribed for:	Medication	Prescribed for:
1.		4.	
2.		5.	
3.		6.	

Are you allergic to any of the following (Please fill in the appropriate box)?

□ Aspirin	□ Penicillin	□ Codeine	□ Metals	□ Novocain	□ Latex	□ Acrylic
□ Other medications (list):						

Do you have, or have you had, any of the following?

□ **AIDS/HIV**	□ **Chest Pain**	□ **Herpes**	□ **Liver Disease**	□ **Shingles**
□ **Alzheimer's Disease**	□ **Cold Sores**	□ **Hay Fever**	□ **Low Blood Pressure**	□ **Sinuses Problems**
□ **Anaphylactic Shock**	□ **Congenital Disorders**	□ **Heart Attack/Failure**	□ **Lung Disease**	□ **Stomach Problem**
□ **Anemia**	□ **Convulsions**	□ ***Heart Murmur**	□ ***Mitral Valve Prolapse**	□ **Stroke**
□ **Angina**	□ **Cortisone Medicine**	□ **Pace maker**	□ **Pain in Jaw Joints**	□ **Swellings**
□ **Arthritis/Gout**	□ **Diabetes**	□ **Heart Disease**	□ **Parathyroid Disease**	□ **Thyroid Problems**
□ ***Artificial Heart Valve**	□ **Drug Addictions**	□ **Hemophilia**	□ **Psychiatric Care**	□ **Tonsillitis**
□ ***Artificial Joint**	□ **Easily Winded**	□ **Hepatitis**	□ **Radiation Therapy**	□ **Tuberculosis**
□ **Asthma**	□ **Emphysema**	□ **High Blood Pressure**	□ **Recent Weight Loss**	□ **Tumors / Growth**
□ **Blood Disease**	□ **Epilepsy / Seizures**	□ **Hives or Rash**	□ **Renal Dialysis**	□ **Ulcers**
□ **Breathing Problems**	□ **Excessive Bleeding**	□ **Hypoglycemia**	□ ***Rheumatic Fever**	□ **Venereal Disease**
□ **Bruise Easily**	□ **Fainting / Dizziness**	□ **Irregular Heart Beat**	□ **Rheumatism**	□ **Other:**
□ **Cancer**	□ **Frequent Cough**	□ **Kidney Problems**	□ **Scarlet Fever**	
□ **Chemotherapy**	□ **Frequent Headaches**	□ **Leukemia**	□ **Sickle Cell Anemia**	

* Conditions that may require premedication

Have you ever had any other serious systemic illness not listed above? □ Yes □ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.	
SIGNATURE OF PATIENT OR GUARDIAN	**DATE**

Dr. Comments:	**Reviewed by:**
	Date:

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PATIENT CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION-A: PATIENT INFORMATION

Name: ___________________________________ Relationship to Patient ___________________________________

Address: ____

Telephone: _______________________________ Email: ____

Social Security # ___________________________ Date of Birth: ____

SECTION-B: TO THE PATIENT—PLEASE READ CAREFULLY

By signing this form you will consent to our use and disclosure of your protected health information to carry-out treatment payment activities and healthcare operations. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent form. Our notice provides a description of our treatment payment activities and healthcare operations and the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent form and we strongly recommend you to read it carefully and understand it completely before signing this consent.

You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent. In such case you will be given 30 days written notice to seek the care of another health care professional and request a transfer of records.

SECTION-C: PATIENT SIGNATURE

I, ____________________________, have taken full opportunity to read and consider the contents of this consent form as well as Notice of Privacy Practices. I understand that by signing this consent form I am giving my full consent to your use and disclosure of my protected health information to carry out all treatment, payments, and related health care operations.

SIGNATURE: ____ DATE: ______________________
RELATION TO PATIENT: ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________, have received a copy of this dental office's Notice of Privacy Practices.

Name (print): _______________________________ Signature: _______________ Date: ________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, were unable because:

- Individual refused to sign this form
- Communications barriers prohibited us from obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other, (please specify):

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Signature Form

Dear Patient,

In order to minimize the number of forms that we have to keep and to reduce the amount of paper wasted, we created a signature form that summarizes all of the forms you are to read and sign prior to becoming our patient. Please sign on each line indicating that you have read and agreed to it. If you do not wish to keep the copy of any form, please return to the receptionist. Thank you.

_________________ I have read, understood, and agreed to the Dental Discovery's General Dentistry Consent Form.

_________________ I have read, understood, and agreed to the Dental Discovery's Notice of Privacy Practices.

_________________ I have read, understood, and agreed to the Dental Discovery's Assignment of Insurance Benefits Form.

_________________ I have read, understood, and agreed to the Dental Discovery's Financial Policy.

_________________ I have read, understood, and agreed to the Dental Discovery's Oral Screening Consent Form. The fee for the enhanced ViziLite Plus oral cancer exam is $59.99. (Please mark appropriate box below)

- □ I authorize the clinician to perform ViziLite Plus exam.
- □ I would prefer not to have enhanced exam at this time.

Print patient (guardian) name ____

Date ________________