

# Confidential Dental and Medical History

## Patient Information

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

SS# \_\_\_\_\_ Marital Status: **SINGLE MARRIED WIDOWED DIVORCED**

Drivers License # \_\_\_\_\_ State Issued \_\_\_\_\_

E-mail \_\_\_\_\_ Best Contact- **EMAIL CELL TEXT HOME** Best Time to Reach You- \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Phone: (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Do you have dental insurance? **YES NO** If yes, please complete the Insurance Information form

**HOW DID YOU HEAR ABOUT US ?** \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_ **Pharmacy Phone #:** \_\_\_\_\_

## Parent of MINOR Child Information

**Mother Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **SS#:** \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Driver License #: \_\_\_\_\_ State Issued: \_\_\_\_\_

**Father Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **SS#:** \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Driver License #: \_\_\_\_\_ State Issued: \_\_\_\_\_

**Who is responsible for payment?** \_\_\_\_\_



Derrick Carter D.M.D.  
571 S. 6th St.  
Macclenny, FL 32063  
904.653.3333

# Medical History

In order for us to provide you with the safest and best possible care, please complete these Medical & Dental History forms. All information is kept **strictly confidential**.

Sex: **Male** **Female**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

<b>Women:</b> Are you pregnant?	Yes / No _____
If yes, what is your estimated due date?	_____
Are you nursing?	Yes / No _____

Do you have or have you ever had:

	YES	NO		YES	NO		YES	NO
Artificial Joints / Joint Replacement	_____	_____	Heart Attack	_____	_____	High Blood Pressure	_____	_____
Congenital Heart Condition	_____	_____	Diabetes	_____	_____	Radiation Therapy	_____	_____
Artificial Heart Valve	_____	_____	HIV	_____	_____	Abnormal Bleeding	_____	_____
Heart Murmur	_____	_____	Stroke	_____	_____	Bruise Easily	_____	_____
Endocarditis	_____	_____	Hepatitis	_____	_____	Sinus Problems	_____	_____
*Heart Transplant	_____	_____	Cancer	_____	_____	Tuberculosis	_____	_____

Are you taking or *have you ever taken* Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa)..... **Yes / No**

**Have you ever been advised to take antibiotics prior to dental treatment for conditions not related to your teeth?**

**Yes / No** For what condition? \_\_\_\_\_

Any surgeries and/or hospitalizations? **YES NO Explain:** \_\_\_\_\_

Have you ever had any excessive bleeding requiring special treatment? **YES NO** \_\_\_\_\_

Use of alcohol: **YES NO | DAILY WEEKLY MONTHLY** Use of recreational drugs: **YES NO**

Do you use tobacco? **YES NO** What type and how much per day? \_\_\_\_\_

**Please list ALL medications you are on:** \_\_\_\_\_

**Are you allergic to any of the following?**

	YES	NO		YES	NO	Other	Yes	NO
Dental Anesthetics	_____	_____	Tetracycline	_____	_____	Please list: _____		
Latex	_____	_____	Sulfa Drugs	_____	_____	_____		
Codeine	_____	_____	Aspirin	_____	_____	_____		
Erythromycin	_____	_____	Metals	_____	_____	_____		
Penicillin	_____	_____	Jewelry	_____	_____	_____		

Are there any other conditions we should know about? \_\_\_\_\_

**PLEASE READ THE FOLLOWING CAREFULLY:** To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetic or pre-medications which may be deemed advisable.

Signature of Patient or Guardian

Print

Date



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# Financial Agreement

By signing this document, I agree that my signature on file shall represent consent for all charge card transactions. I also understand that Dr. Carter's office both reports to and uses credit bureau files for purposes of finance and collection of accounts and any and all charges incurred in order to collect on a past due balance are also my responsibility. Parental consent for treatment determines account responsibility. My signature below also acts as signature on file for insurance claims and I give permission to Derrick Carter, DMD to file and disclose my health information to my insurance company.

I have read and understand the terms of the financial agreement with Derrick Carter, DMD. My signature below represents agreement and consent to these terms.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\*\*\*\*\*

## Acknowledgment Of Receipt Of Notice Of Privacy Practices

(You May Refuse to Sign This Acknowledgment)

I have received a copy of the NOTICE OF PRIVACY PRACTICES. I hereby authorize you to share/disclose my health information with the following persons/parties:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**SIGNATURE OF PATIENT or if minor,  
SIGNATURE OF LEGAL GUARDIAN**

### **OFFICE USE ONLY:**

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES document, but did not because:

- It was emergency treatment  
 I could not communicate with the patient  
 The patient refused to sign  
 The patient was unable to sign because

\_\_\_\_\_  
 Other (please describe) \_\_\_\_\_  
\_\_\_\_\_

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority/relationship.

\_\_\_\_\_  
\_\_\_\_\_



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# Insurance Information Form

## Primary Insurance

Subscriber's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Subscriber Phone: \_\_\_\_\_

Employer/Co. Name \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer/Co. Address, City, State, Zip \_\_\_\_\_  
\_\_\_\_\_

Insurance Carrier's Name \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Carrier Address, City, State, Zip \_\_\_\_\_  
\_\_\_\_\_

### **OFFICE POLICY REGARDING INSURANCE:**

Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf.

I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to Derrick Carter, D.M.D. at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim, including your social security number, will require full payment at the time of service. Any portion of treatment that the insurance does not cover is the patient's responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company after 45 days. I hereby authorize the release of any dental information that is needed to file my insurance.

I consent to treatment for myself/family under 18 years old. I have read the above statements and understand that I am responsible for payment in full after (45) days of my treatment, regardless of any delay in payment(s) by my insurance company. I understand that a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility.

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Signature of Patient or Guardian	Print Name	Date
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