ELZA M. PEREIRA D.M.D.

FAMILY DENTISTRY

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

Patient Information

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

Email: ☐ I would like to receive correspondence via email.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref Dentist:

Employer ID: Pref Pharmacy:

Carrier ID: Pref Hyg:

Section 3

941 921 3121

info@lovesmilesdentistry.com

7129 Curtiss Ave. Ste.6
Sarasota, FL 34231

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deductible:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deductible:

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NEW PATIENT MEDICAL HISTORY

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of the entire body. Health problems that you may have, or medications that you may be taking can affect your treatment plan.

Are you under a physician's care now?	☐ Yes	☐ No	If yes: _____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes: _____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes: _____
Are you taking any medications, pills or drugs?	☐ Yes	☐ No	If yes: _____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	If yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes: _____
Do you use tobacco?	☐ Yes	☐ No	If yes: _____
Do you use controlled substances?	☐ Yes	☐ No	If yes: _____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Other	If Other, please specify: _____		

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

AIDS/HIV Positive	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	Angina	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No
Excessive Thirst	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No
Fainting Spells/Dizziness	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Pain in Jaw Joints	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Parathyroid Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Hepatitis A	☐ Yes	☐ No	Anaphylaxis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Artificial Heart Valve	☐ Yes	☐ No
Shingles	☐ Yes	☐ No	Artificial Joint	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No

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Liver Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No
Yellow Jaundice	☐ Yes	☐ No			

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes: _____

Comments:

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

_____ Date: _____

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HIPAA PATIENT CONSENT FORM

I understand that I have certain rights regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize the office of Dr. Elza Pereira, D.M.D. to use and disclose my protected health information to carry out the following:

- Treatment (conduct, plan and direct my treatment and follow-up among multiple healthcare provider who may be involved in treatment directly or indirectly}
- Obtain payment from third-party payers
- Conduct normal healthcare operations

I have been informed of and given the right to review and secure a copy of The Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that this office reserves the right to change the terms of this notice from time to time and I may contact this office at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but this office is not required to agree to these restrictions. I understand that I may revoke this consent at any time, however this office may condition/restrict treatment. I understand no insurance can be billed on my (patient's) behalf without this signed HIPAA consent form.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Signed Date: _____

Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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