

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
 Last Name _____
 First Name _____ Middle Initial _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
 Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____ Relationship to Patient _____

3 PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext _____ Cell Phone (____) _____

Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

4 DENTAL HISTORY

| | | |
|--|--|---|
| Reason for today's visit _____ | Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Former Dentist _____ | Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| City/State _____ | Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of last dental visit _____ | Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of last dental X-rays _____ | Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Place a mark on "yes" or "no" to indicate if you have had any of the following: | Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No | Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No | Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you floss? _____ |
| | Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you brush? _____ |
| | Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No | |

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HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | | | | |
|--|--|-----------------------|--|---------------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

| | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

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UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

LYSANDRO O. TAPNIO D.M.D. P.A.

“The Gentle Dentist”

* 904-641-0944 *

Office Policy

Thank you for choosing us as your dental care provider. We are committed to providing you the highest quality dental care, utilizing the best materials and education available. The following is a statement of our Office Policy, which we require you read and sign prior to any treatment.

All patients must complete our Patient Registration and History form before seeing the doctor.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. Our office accepts cash, personal checks, Discover, MasterCard, Visa, and American Express. We also offer Care Credit as a financing option. We can even apply for you here in the office and give you an instant answer! Returned checks and balances older than 60 days are subject to collection fees and interest charges.

Minor Patients

The parent, guardian, or adult accompanying a minor is responsible for full payment at time of visit. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved form of payment at the times of services has been verified.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party in that contract. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. **In the event your insurance doesn't pay for a procedure, you are responsible for any remaining balance.**

Appointment Policy

It is our policy for you to give us 48 hours' notice if you need to change an appointment, and for you call and speak directly with a staff member as our answering machine does not accept changes or cancellations. We will not charge for your first missed appointment. However, if you miss an appointment a second time we will reschedule when you pre-pay for the treatment in full. If you keep the appointment, the payment will be applied towards treatment. However, if you fail to keep the appointment a second time, the payment will be applied towards lost production time. **Would you like us to remind you of your upcoming appointments?**

**Please opt-in or out - YES VIA: (circle as many as apply) Call/leave voicemail Text
E-mail NONE**

Thank you for understanding our Office Policy. Please let us know if you have any questions or concerns. We are committed to proving the most positive experience in dental care.

X _____
Signature of patient or responsible party

Date _____

LYSANDRO O. TAPNIO D.M.D. P.A.
9272 Arlington Expressway
Jacksonville, Florida 32225
(904) 641-0944

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____ acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization of behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. PROCESS ALL INSURANCE CLAIMS
2. TO ENSURE PAYMENT FOR SERVICES RENDERED
3. TO RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES
4. TO RELEASE INFORMATION TO OTHER MEDICAL/DENTAL PROVIDERS, WHEN NECESSARY, FOR YOUR TREATMENT
5. Get Xrays emailed to us from previous doctors

I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all medical and surgical benefits, including major medical benefits in which I am entitled, to DR. LYSANDRO TAPNIO. This assignment will remain in effect until revoked by me *in writing*. A photocopy of this assignment is to be considered as valid as the original.

Patient _____ Responsible Party _____ Date _____
(parent, if minor)