

Coastal Dental Services <<<>> Dentures & More

Southside Office

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www.FLDental.com

Confidential Personal Information and Medical & Dental History (Page 1 of 5)

PERSONAL INFORMATION QUESTIONNAIRE

Optimum health service is our dedicated objective. In order to render this service with excellence and safety it is necessary to become acquainted with vital information related to each patient. The following "Personal Information" & the "Confidential Medical History" questionnaires are therefore important to your dental treatment in this office. Please take care to carefully and truthfully answer every question on these forms. If you need more space, please use the third sheet to supplement your answers or to provide additional required information. Your answers to these questions are confidential and will be for this office's use to aid in your treatment.

PATIENT NAME: _____ BIRTHDATE: _____ SSN: _____
First Initial Last Name

MAILING ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____

RESIDENCE PHONE: _____ FAX: _____ CELL: _____ E-MAIL: _____

YOUR OCCUPATION: _____ EMPLOYER _____ WORK PHONE: _____
(Business name if self employed)

SPOUSE, PARENT or NEAREST OF KIN: _____ EMERGENCY PHONE #: _____

SPOUSE OCCUPATION: _____ EMPLOYER _____ WORK PHONE: _____
(Business name if self employed)

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT _____ SSN: _____

FORMER DENTIST: _____ TOWN: _____ TELEPHONE: _____ FAX: _____

APPROXIMATE DATE OF LAST VISIT: _____ TREATMENT RENDERED: _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

HAVE YOU SEEN OUR ADVERTISEMENT:

IN THE YELLOW PAGES? ; THE FL TIMES-UNION? ; H-MAGAZINE? ; HEALTH SOURCE? ;
WEBSEARCH? ; FLDENTAL.COM? ; RADIO? ; TV? ; OTHER? _____

METHOD OF PAYMENT: CASH , CHECK , MEDICAID , VISA/MASTERCARD/DISCOVER

DO YOU HAVE DENTAL INSURANCE? Yours: , or Spouse's: . IF SO, POLICY OWNER'S SS# _____

NAME OF POLICY _____ GROUP/EMPLOYER'S NAME _____

(If you have insurance, please provide insurance information/card & **completed and signed claim forms** when turning in this form – if you have insurance, please advise the receptionist – she will give you the Office's Insurance Policy form. Please read and familiarize yourself with this policy.)

IF YOU ARE HAVING DENTURES PARTIALS IS THIS THE INITIAL PLACEMENT? Yes No

IF NOT INITIAL PLACEMENT, DATE OF PRIOR PLACEMENT: Month: _____ Year: _____

I hereby attest to the information listed above as to its accuracy and correctness – If there is any change in my health or medications, I will inform the doctor or his assistant prior to any treatment. By signing this form I authorize release of medical information to associated medical/dental providers, insurance companies of which I am an insured, &/or other entities legally authorized by Florida State Law to possess my medical/dental treatment & condition records.

Signature: _____

Date: _____