Dr. Melanie Holden, DMD

HEALTH QUESTIONNAIRE

Patient's Name: _____ Preferred name (if different): _____

Date of Birth: _____ Spouse / Guardian: _____

Local Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____

Marital Status: _____ Email: _____

Secondary Address: _____ Secondary Phone _____

Employer's Name: _____

Employer's Address: _____ Work Phone: _____

PLEASE ANSWER EACH QUESTION (CIRCLE YES OR NO)

YES NO Have you been under the care of a physician during the past two years?
For what purpose? _____ Physician's Name: _____

YES NO Are you taking any medications?
Please list: _____

YES NO Are you allergic to any drug or medicine? (Penicillin, Codeine, Local Anesthetics, etc)
Please list: _____

YES NO Have you ever had any excessive bleeding requiring special treatment during an operation or dental extraction?

YES NO Are you required to take antibiotic pre-medication prior to dental treatment?
For what purpose? (check one) ❑ Joint replacement ❑ Congenital heart defect ❑ Artificial heart valve

YES NO Have you ever taken a bisphosphonate drug (like Fosamax or Boniva) or any drug for osteoporosis or bone cancer?

YES NO Have you ever used tobacco? YES NO Do you currently use tobacco?

YES NO (Women) Are you currently pregnant or breastfeeding? (Circle one)

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

Heart Trouble	Hepatitis - Type _____	Sinus Trouble	Radiation to Head or Neck
Heart Attack	Diabetes 1 or 2	Cancer	Organ Transplant
Congenital Heart Defect	Tuberculosis	Anemia	Prosthetic Heart Valve or Heart Valve Replacement
Heart Murmur	Herpes	HIV / AIDS	Stroke
High Blood Pressure	Arthritis	Osteoporosis	Alzheimers
Low Blood Pressure	Epilepsy	Parkinson's Disease	Kidney Disease
Asthma or COPD	Rheumatic Fever	Prosthetic Joints Knee or Hip	Liver Disease

OTHER _____

If you have any of these, please explain: _____

_____

In case of emergency, who should be notified and phone number: _____

When was your last dental examination and cleaning? _____

Purpose of today's appointment/dental complaint: _____

Have you visited a dentist regularly in the past? _____

Former Dentist _____

How did you hear about our office? ❑ Friend or Relative ❑ Newspaper ❑ Yellow Pages ❑ Online ❑ Other

If friend or relative, who may we thank for recommending our office? _____

I hereby authorize Dr. Melanie Holden, D.M.D. and/or legally qualified auxiliaries/associates to administer any treatment and anesthetics, as may be deemed necessary or advisable in the diagnosis and treatment of me (or my children, if I am a parent and have left him/her in the dentist's care). I understand I will be consulted before treatment is rendered. I understand the need for these questions to be answered truthfully. All questions have been answered truthfully and in my own hand.

Signature _____ Date _____

(PATIENT OR MINOR'S PARENT OR GUARDIAN)

PLEASE FILL OUT REVERSE SIDE ➡

Patient Financial Responsibility - Our office does not accept any dental insurance, but we will assist with filing insurance claim for reimbursement directly to the patient.

Name of responsible party (if other than self) _____

Relationship to Patient: _____

Work Phone Number: _____ Home number if different from patient: _____

Patient Consent to Communication Delivery Method

Do we have permission to:

Leave the following information on your home answering device (check all that apply)

❑ Appointment information

❑ Billing information

❑ Dental information

Leave the following information on your cell phone voicemail (check all that apply)

❑ Appointment information

❑ Billing information

❑ Dental information

I give permission to share appointment information with the person(s) named below:

Name: _____

I give permission to share billing information with the person(s) named below:

Name: _____

I give permission to share dental information with the person(s) named below:

Name: _____

Please read and ask the front desk if you have any questions.

I certify that I have read and understand the above information to the best of my knowledge. The questions on the front and back have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize I Love My Dentist Sarasota, PLLC to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependant to my insurance company, other health practitioners, or any authorized party listed above. This may be done electronically via secure internet connections. I agree to be responsible for the payment of all services rendered on my behalf of my dependants. I understand payment is due at the time of service, and in case by default I may be responsible for reasonable attorney's fees and all costs of collections. Payment default will also be processed/prosecuted in accordance with Florida law through the State's Attorney's Office.

I, the patient, have been informed of my financial responsibility and will comply with this policy and I have read and fully understand the Privacy Act Notices of I Love My Dentist Sarasota, PLLC and agree and consent to this policy. (See Notice)

❑ _____ **Date** _____