Tampa Dental – Acquaintance Form
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Welcome to our office. We do our best to make your appointments as convenient as possible. If at any time you have questions regarding your treatment, appointment, or fees, please feel free to ask. This "Acquaintance Form" will help us serve you better.

PLEASE PRINT Today's Date _____

Mr./Mrs./Ms./Dr._____
Last Name First Name Middle Initial

□ Minor □ Single □ Married □ Widowed □ Divorced □ Separated

If child, parent's full name _____

Residence Address _____

City _____ State _____ Zip _____ Date of Birth _____

Home Phone _____ Cell Phone _____ Email _____

Occupation _____ Employer _____

Business Address _____ Work Phone _____ Ext. _____

Do you have dental insurance? _____ If yes, what is the name of your insurance company _____

Group Number _____ SS # _____ Driver's License Number _____

Please tell us whom we may thank for referring you to our office. _____

Has any member of your family ever been treated in our office? _____ If yes, whom? _____
How did you hear about us? Ad _____ Phone Book _____ Web Site _____ Other _____

Dental History

What is the purpose of your visit today? _____

Has fear or discomfort kept you from regular visits? _____

Describe _____

How long has it been since your last dental appointment? _____

Do you prefer nitrous oxide sedation (tranquilizing air) during treatment? _____

How would you describe your present dental health? □ Good □ Fair □ Poor

Please check (√) if you have had problems with any of the following:

□ Bad breath	□ Grinding teeth	□ Sensitivity to heat
□ Bleeding gums	□ Loose teeth or broken fillings	□ Sensitivity to sweets
□ Clicking or popping jaw	□ Periodontal treatment	□ Sensitivity when biting
□ Food collection between teeth	□ Sensitivity to cold	□ Sores or growths in mouth

How often do you floss? _____ How often do you brush? _____

How do you feel about your smile? _____
_____

(Form revised-July, 2009)

Tampa Dental
Medical History

Patient's Name _____ Today's Date _____

Physician's Name _____ Date of last visit _____

Have you had any serious illness or operations? _____ Describe _____

_____

Have you ever had a blood transfusion? _____ If yes, give approximate dates _____

Have you had a joint replacement? _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth control pills? ☐ Yes ☐ No

_____

Check (√) if you have had any of the following:

☐ AIDS	☐ HIV Positive	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Cough, Persistent	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough up Blood	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Heart Valves	☐ Diabetes	☐ Cortisone treatments	☐ Shortness of Breath
☐ Artificial Joints	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Swelling of feet/ankles
☐ Back Problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Blood Disease	☐ Headaches	☐ Nervous Problems	☐ Tobacco Habit
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Problems	☐ Psychiatric Care	☐ Tuberculosis
☐ Chemotherapy	Describe _____	☐ Radiation Treatments	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease	☐ Venereal Disease

_____

Are you currently taking HRT, or Fosomax, Boniva or other Bisphosphonates? (please list)_____

List medications you are currently taking (over the counter and prescription) _____

_____

Pharmacy Name _____ Location _____ Phone # _____

_____

Do You Have Allergies to? ☐ Aspirin ☐ Penicillin ☐ Barbiturates (sleeping pills) ☐ Sulfa ☐ Codeine ☐ Local Anesthetic

☐ Latex ☐ Foods (please list)_____

Other Allergies: _____

(Form Revised July, 2009)

TAMPA DENTAL
6421 Sheldon Road
Tampa, Florida 33615

I acknowledge that I have received a copy of Tampa Dental's Notice of Privacy Practices.

Date _____

Print Name: _____

Signed: _____

If signing as a parent or guardian, please note the name of the patient : _____

I give employees of Tampa Dental permission to speak to the following people regarding my care:

Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Form Revised July, 2009)

Tampa Dental

RESPONSIBILITY AND CONSENT

I hereby authorize and request the performance of dental services for myself or my minor child. I give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or the supervised staff for diagnostic purposes or dental treatment.

_____

Date: **Signature of patient or Parent/guardian if patient is a minor**

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned have insurance with _____

Name of insurance company(ies)

and assign directly to Tampa Dental all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges regardless of insurance coverage. I have provided Tampa Dental with all information necessary to secure the payment of benefits. Additionally, I authorize the release of any information relating to this claim and authorize the use of this signature for all my insurance claims whether manual or electronic.

_____

Date: **Signature of Patient/insured person**

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, including any percentages not covered by my insurance carrier. I understand that in the event I default in my payment for said services I can be charged an amount to cover collection or attorney fees.

_____

Date: **Signature of patient or parent/guardian**

(Form Revised July, 2009)

Tampa Dental Cancellation and No Show Policy

Tampa Dental is committed to providing you with quality customer service and patient care in a timely fashion. We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled 24 hours in advance in order to give us adequate time to fill your appointment.

Our doctors and hygienists want to be available for your needs as well as the rest of our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce the following changes below.

Effective Immediately:

- There will be a charge of $50 for a broken appointment or cancellation with less than 24 hours notice.
- After the third broken appointment the patient will be dismissed from the practice and asked to continue treatment elsewhere.
- Appointments with a hygienist of 1 ½ hours or more must be prepaid in order to reserve that appointment.
- Appointments with the doctor of 2 hours or more must be reserved with a deposit of at least half the amount of what the patient's estimated portion will be for that appointment.
- All Sedation appointments, regardless of the length, must be prepaid at least 48hrs in advance in order to reserve your appointment time.

Please keep in mind that payments are based on insurance estimates unless pre-approved by insurance prior to treatment. The final, out of pocket portion for the patient could change (up or down) once treatment is completed, depending on the amount covered by insurance or if treatment changed at the time of the appointment.

Patient Name (Please print): _____

_____ _____

Patient Signature **Date**

Create the Smile You Deserve

Your Personal Smile Evaluation

Completion of this form is voluntary and optional.

Name: _____ **Date:** _____

When I see a picture of myself:

_____**I wish my teeth were whiter.**

_____**I wish I had a wider or broader smile.**

My teeth are: _____**crowded** _____**crooked** _____**uneven** _____**overlapped**

_____**My teeth have rough edges.**

My gums show _____**too much** _____**not enough when I smile.**

_____ **My top teeth don't show enough.**

_____ **There is too much space between some of my teeth.**

_____ **I have discolored areas between my teeth.**

_____ **I am not totally pleased with my smile.**

_____**I sometimes hesitate to smile.**

_____ **I am interested in options available for enhancing my smile.**

_____ **I have other concerns regarding my smile.**

Cosmetic Services Are Not Covered By Insurance