WELCOME TO THE PRACTICE!

William D. Titus, DMD, PA. • General & Cosmetic Dentistry • 542182 U.S. Highway 1 • Callahan, FL 32011 • 904-879-3786
www.williamdtitusdmd.com / e-mail: wdtitusdmd@williamdtitusdmd.com

CONFIDENTIALITY NOTICE

We do not share patient information with any other party and comply with the Health Insurance Protection and Portability Act as instituted by federal legislation. Only YOU can request copies of your records and such requests must be in writing.

PATIENT INFORMATION

Name:_____
(LAST) (FIRST) (M.I.)

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Emerg. Phone:_____

e-Mail:_____@_____

Date of Birth:____/_____/_____ SSN:_____-_____-_____

Drivers License:_____ _____
(NUMBER) (STATE)

SPOUSE INFORMATION

Marital Status: ☐Single ☐Married ☐Sep ☐Divorced ☐Widowed

Spouses Name:_____

Date of Birth: _____/_____/_____ SSN:_____-_____-_____

Insurance Coverage for Spouse on your policy: ☐ Yes ☐ No

Insurance Coverage from Spouse's Policy: ☐ Yes ☐ No

PATIENT 'S EMPLOYER INFORMATION

Employer:_____

Phone:_____ Occupation:_____

ATTENTION: PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT.

INSURANCE INFORMATION

Primary Insurance Policy

Insured Name:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Insured's SSN: _____-____-_____ Subscriber Pt. here? ☐ Yes

Carrier Name:_____

Policy (Group or Plan)#:_____

Member #: _____

Employer:_____ Fee Schedule:_____

Type: ☐ Indemnity ☐ PPO ☐ Discount ☐ Managed Care

Secondary Insurance Policy

Insured Name:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Insured's SSN: _____-____-_____ Subscriber Pt. here? ☐ Yes

Carrier Name:_____

Policy (Group or Plan)#:_____

Member #: _____

Employer:_____ Fee Schedule:_____

Type: ☐ Indemnity ☐ PPO ☐ Discount ☐ Managed Care

EMERGENCY CONTACT INFORMATION

In an emergency, please provide a name and phone number of someone we should we contact on your behalf?

Their Name: _____

Relationship:_____ Phone:_____

NOTICE TO PARENTS WITH MINOR CHILDREN

No patient under 18 years of age will be treated or examined without a legal guardian present during the entire dental appointment, unless emancipated.

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_____ Date:_____

1. Have you been under the care of a medical doctor for any illness during the past two years? ..... ☐Yes ☐ No
   If so, please list doctor, condition treatment and dates:

Doctor's Name	Condition / Treatment	Date

2. List all medications taken in the last six months:_____
   _____
   _____

3. Are you sensitive or allergic to any medication? ..... ☐Yes ☐ No
4. Are you receiving or have you received treatment for Periodontal Disease?..... ☐ Yes ☐ No
5. Has a physician ever told you to pre-medicate with an antibiotic before dental treatment? ..... ☐ Yes ☐ No
6. Have you had an artificial joint placed within the previous two years? ..... ☐ Yes ☐ No
7. WOMEN ONLY: Are you pregnant? ..... ☐ Yes ☐ No
   Do you anticipate becoming pregnant? ..... ☐ Yes ☐ No
   Are you taking birth control pills? ..... ☐ Yes ☐ No
8. Please circle any of the following conditions which you have been diagnosed with by a physician:

Cardiovascular (Heart/Circulation)

1. Heart murmur
2. Rheumatic fever
3. Mitral valve prolapse
4. Artificial hear valve
5. High blood pressure (hypertension)
6. Low blood pressure
7. Heart disease and / or heart attack
8. Angina pectoris / heart related chest pain
9. Heart pacemaker
10. Heart surgery / vascular stent / by-pass surgery

Kidney, Liver, Gastrointestinal

1. Liver disease
2. Kidney stones
3. Decrease kidney function
4. Elevated liver enzymes
5. Excessive bleeding
6. Hepatitis A Hepatitis B Hepatitis C Other
7. Jaundice
8. G.I. disorder / Crohns Dz. / Diverticulitis / IBS / Other

Neurological

1. Parkinson disease
2. Epilepsy or seizures
3. Motor or movement deficits
4. Sensory deficits
5. Spine, neck or back problems
6. Cerebrovascular accident or STROKE
7. Alzheimer's Dz. or dementia

Miscellaneous

1. Artificial joint
2. Cancer or tumor
3. Leukemia
4. Chemotherapy
5. Radiation Therapy -- if so, to head or neck area? ☐ Yes
6. Anemia
7. Emphysema
8. Tuberculosis
9. HIV, AIDS, or ARC
10. Diabetes: Type I (Juvenile) Type II (Adult Onset)
11. Gastric Ulcers
12. Asthma
13. Sinus problems -- if so, have you had infections? ☐ Yes
14. Thyroid disease
15. Arthritis - Osteo / Rheumatoid
16. Hemophilia
17. Venereal disease (syphilis, gonorrhea, herpes)
18. Organ removal or transplant
19. Glaucoma
20. Prostate / Urinary tract problems
21. Attention deficit disorder / hyperactivity (ADD / ADHD)
22. Psychiatric treatment (depression, anxiety, panic disorder)

Dental History

1. Adult or juvenile periodontal disease
2. Tempromandibular joint dz. (TMJ)
3. Bruxism - grinding of teeth causing wear
4. Mouth ulcers - Lichen planus - aphthous ulcers

To the best of my knowledge, all the preceding answers to this questionnaire are true and correct. If I have any changes in my health or medications, I will notify my dentist at the next appointment without fail.

_____ _____ _____ _____
(SIGNATURE OF PATIENT) (DATE) (SIGNATURE OF DENTIST) (DATE)

Med. Update 1: _____ by:_____ on: ___/___/_____ Med. Update 2: _____ by: _____ on: ____/____/_____