Patient Registration

GENERAL INFORMATION

Patient's name: _____ Date of Birth:_____ Age: _____
FIRST MI LAST

Name you would like us to use when you visit our office: _____

Marital Status:_____ If married, spouse's name: _____

If child, parent's name:_____
MOTHER FATHER

Address: _____

City:_____ State: _____ Zip Code _____

Best telephone number to reach you or leave messages concerning your appointments: _____

ALTERNATE PHONE NUMBERS

Home: _____ Work: _____

Cell Phone:_____ Email: _____

How did you hear about our office?_____

Which form of payment do you prefer to use: ☐ Check ☐ Cash ☐ Credit Card

Family Smiles Fleming Island
1515-1 Business Center Drive
Orange Park Florida 32003
(904) 215-3323

www.familysmiles.com
info@familysmiles.com

Family Smiles Ponte Vedra
151 Sawgrass Corners Drive, Suite 102
Ponte Vedra Beach, Florida 32082
904-543-0568

MEDICAL HISTORY

Please check "yes" or "no" to indicate if you have any of the following:

Abnormal bleeding	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Aids	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Artificial valve or joints	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No
Blood disease	☐ Yes	☐ No	Mitral valve prolapse	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Nervous problems	☐ Yes	☐ No
Chemical dependency	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric care	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Respiratory disease	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No

Do you smoke or use other tobacco products? ☐ Yes ☐ No

Women only: Are you pregnant or possibly pregnant? ☐ Yes ☐ No

Do you have any history of medications for osteoporosis? _____

Please list any medications you are taking: _____

_____

_____

Please check to indicate if you are allergic to any of the following:

Aspirin	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Local Anesthetic	☐ Yes	☐ No
Latex	☐ Yes	☐ No			

Please list any other allergies not listed above: _____

Please indicate any other health information you would like us to know : _____

_____

_____

Patient Signature: _____ Date: _____

Doctor's Notes: _____

_____

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PATIENT REGISTRATION: PAGE 2

Patient's Name: _____

Do you have any specific dental concerns that you would like us to discuss with you today? _____

_____

_____

NEW PATIENT CONSENT

According to Florida law, dentists are responsible for informing patients and obtaining informed consent. This is in an effort to avoid communication errors and misunderstandings.

I, _____, hereby authorize Dr. Mapp or Dr. Scarlett to perform an examination and any necessary x-rays. I understand the responsibility for payment of dental services provided in this office for myself or any dependents on my account is mine. Unless I have insurance, I am responsible for full payment of my services today. I understand the fee for the above services will not exceed: _____.

There is an x-ray that we can take for you that will screen for abnormalities such as tumors, cysts, abcesses, cancer, some carotid artery blockages and other oral pathologies. Many cancers can metastasize to the jaws and can be detected earlier with this x-ray. It is known as a panoramic x-ray and is simple for the patient and painless. The cost of the x-ray is $99.00 and is generally not covered by insurance. Do you wish to have this x-ray taken at this visit today?

☐ Yes ☐ No

I also understand that I have the right to ask questions regarding treatment before it is completed and that I have the right to ask questions regarding fees during my appointment. I understand that after the initial evaluation, I will be given further information regarding the status of my oral health including any findings, proposed procedures, benefits, risks, and alternative treatments. I understand that I may ask questions and that I may also seek a second opinion. I also realize that it is mandatory that I give as accurate and complete medical and personal history as possible.

Patient Signature: _____ Date: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment. The undersigned acknowledges receipt of a copy of the currently effective "Notice of Privacy Practices" for Stephanie Mapp, D.M.D., P.A. A copy of this signed, dated Acknowledgement shall be as effective as the original.

Please sign your name _____Today's Date _____

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority:

_____

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, Yvonne Hawk.

OFFICE USE ONLY

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because _____

- ☐ Other (please describe) _____

Yvonne Hawk – privacy officer:_____

APPOINTMENT CANCELLATION POLICY

To our valued patients: When a patient has a scheduled appointment, that time is reserved ***especially for the patient***. If the patient does not keep this appointment that time is lost. Some patients have to wait several weeks for their treatment, especially if they wish to come in during the more convenient appointment times. In an effort to serve our patients most effectively, we require a 24 hour cancellation notice in order to avoid a ***cancellation fee of $25***. Patients who cancel or no-show for multiple appointments will be discharged from our practice.

Thank you,

Dr. Mapp, Dr. Scarlett, and Staff

Signature of Patient (or parent of child): _____

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