COCONUT GROVE SMILE
2820 Oak Av, Coconut Grove, FL, 33133

T: (305) 460-4499 F: (305) 441-0883
dentist@coconutgrovesmile.com

**Welcome to our practice!**

Please fill out the enclosed documents. You may choose to fax or email them back to us prior to your appointment or you may bring them with you to your appointment in order to expedite your check in process.

**Today's Date:** ________________________ **Patient's full Name**: ________________________________________

**Nickname:** __________________________ **Date of Birth:** ____________________________________________

**Street Address**: ______________________________________________ **Apt:** _____________________________

**City:**____________________ **State:**_________________ **Zip Code:** _______________________________

**Social Security:** _____________________________________ Marital Status: _________________________________

**Email address**: ________________________________________________________________________________

**Cell Phone**: ________________________ **Work Phone:** ______________ **Home phone:** ____________________

**Occupation:** ___________________________________ **Employer:** _____________________________________

**Employer's Full Address:** _________________________________________________________________________

**Physicians Name:** ___________________________________________________ **Phone:** ___________________

**Insurance:**
Do you have dental insurance? Yes No **If yes, please answer the questions below. If no, please skip section.**

**Insurance Company:** _____________________________________________ Phone: ______________________

**Member ID:** ______________________________________ **Group number:** ______________________________

**Primary policy holder:** ______________________________________ SS**#:** _____________________________

Relationship to patient: __________________________________________________________________________

Home Phone: ____________________________________________ Work Phone: ________________________

Employer: _______________________________________________________________________________________

**Person responsible for this account (please state "self" if applicable):**

Relationship to patient: ____________________________________________________________________________

Full Address: ____________________________________________________________________________________

Cell phone: ____________________ Work Phone: _______________________ Home phone: __________________

**How did you hear about us**? If a Patient referred you, please provide name___________________________________

Otherwise circle below:

Internet Google Yelp Zoc Doc Insurance Company Office Website Facebook Walked by

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## MEDICAL HISTORY

**Sex**: Male___ Female___

If female, please answer the following:

Are you taking Birth Control Pills? Yes No

Are you pregnant? Yes No If Yes, # of weeks [ ]

Are you nursing? Yes No

**Height**: _____ **Weight**: _____ lb **Do you smoke or use tobacco?** Yes No How often? _________________

**Please circle the conditions that apply to your medical history**

| | | |
|---|---|---|
| Glaucoma | Seizures | Artificial Bones |
| High Blood Pressure | Shingles | Artificial Heart Valve |
| Pace Maker | Sickle Cell Anemia | Asthma |
| Pneumocystis | Sinus Problems | Blood transfusion |
| Kidney Problems | Stroke | Cancer |
| Radiation Therapy | Thyroid problems | Chemotherapy |
| Rheumatic Fever | Tuberculosis | Colitis |
| HIV+A\|DS | Ulcers | Congenital Heart Defect |
| Liver Disease | Venereal disease | Cosmetic Surgery |
| Hay Fever | Yellow Jaundice | Diabetes |
| Heart Attack | Abnormal bleeding | Difficulty Breathing |
| Heart Surgery | Alcohol Abuse | Drug abuse |
| Mitral Valve Prolapse | Allergies | Emphysema |
| Psychiatric Problems | Anemia | Epilepsy |
| Hemophilia | Angina pectoris | Fainting Spells |
| Hepatitis A B C | Arthritis | Fever Blisters |
| Low Blood Pressure | | Frequent Headaches |

## ALLERGIES

Please circle any that apply

Latex Penicillin Aspirin Sulfa Tetracycline Metals

Other (please mention) ________________________________________________

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Please write down all the Medications that you are currently taking:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Is there any other disease, condition, or problem that you think this office should know about that is not covered above? Please describe: ______________________________________________________________

**Emergency Contact:** ___________________________________ **Phone:** ______________________

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I WILL LET DR. MOLINARI KNOW IF THERE ARE ANY KNOWN CHANGES IN MY MEDICAL HISTORY.**

**PATIENT'S / GUARDIAN'S SIGNATURE** ______________________________ **DATE:** ________________

## DENTAL HISTORY

1. Purpose of initial visit______________________________________________________
2. Are you aware of a problem? Explain__________________________________________
3. How long since your last dental visit? ________________________________________
4. Previous dentist's name? ____________________________________________________
   a. What was done at that time? ________________________________________________
   b. Address_________________________________________ Tel. ___________________
5. When was the last time your teeth were cleaned? _______________________________
6. Have you made regular visits? YES NO
7. When was the last time you had dental x rays taken? ____________________________
8. Have you lost any teeth or have any teeth been removed? YES NO
   a. If yes, why? ____________________________________________________________
      i. How have they been replaced? ___ Have not been replaced ___ Fixed bridge Age:
         ___ Removable partial Age; ___ Denture Age: ___ Implants Age:
   b. Are you unhappy with the replacement? YES NO
      i. If yes, explain: _________________________________________________________
9. Have you had any problems or complications with previous dental treatment YES NO
   a. If yes, explain: _________________________________________________________
10. Do you clench or grind your teeth? YES NO
11. Does your jaw click or pop? YES NO
12. Have you experienced any pain or soreness in the muscles of your face or around your ear? YES NO
13. Do you have frequent headaches, neck aches or shoulder aches? .... YES NO
14. Does food get caught in your teeth? YES NO
15. Are any of your teeth sensitive to: HOT COLD SWEETS PRESSURE
16. Do your gums bleed or hurt? YES NO If yes, when? _____________________________

17. How often do you brush your teeth? ___________________________________________
18. Do you use dental floss? YES NO If yes, how often? ______________________________
19. Are any of your teeth loose, tipped, or chipped? YES NO
20. Are you unhappy with the appearance of your teeth? YES NO
    a. If yes, explain_____________________________________________________
21. Do you feel your breath is offensive at times? YES NO
22. Have you ever had gum treatment or surgery? YES NO
    b. If yes, what? _____________________________________________________
    c. Where? ______________________________________ When? ________________
23. Have you had any orthodontic work? YES NO
24. Describe any unpleasant dental experiences or anything about dentistry that you strongly dislike:

    ___________________________________________________________________
25. Do you have any questions or concerns? YES NO

26. If yes, explain_____________________________________________________
27. Please rate your smile from 1 to 10 ___________________________________________

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. PATIENT'S / GUARDIAN'S**

**SIGNATURE**______________________________ **Date:** ________________________

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement*

**I _____«SD_PAT_1->FULLNAME»_____ HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.**

**SIGNATURE_______________________________________________________ DATE: ______________**

## FINANCIAL AGREEMENT / CANCELLATION POLICY

**Welcome to our Fee for Service Dental Practice**.

By signing this document you enter into a financial agreement with **Coconut Grove Smile Dental Office.**
Payment is expected in full at time of service. Even though we might bill your insurance as a courtesy to you; ultimately you are responsible for all fees including those procedures not covered by insurance and unbeknown to us at the time of the service. These may include deductibles, co-insurance, non- covered procedures, non-covered materials, radiographs, etc.

By signing this agreement, I, _«SD_PAT_1->Acct->G1TtlAndName»______assume full responsibility of all fees associated with the procedures performed on me and/or my child ___________________________. I also understand that any unpaid balance over 60 days will thereafter bear interest at the annual percentage rate of l8% until paid. I also agree to reimburse **Coconut Grove Smile Dental** PA the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs, and expenses including reasonably attorney's fees, the practice incur in such collection efforts..

I understand that cancellations are very common in dental offices and **Coconut Grove Smile Dental Office** will incur in some unexpected expenses if I am to cancel my appointment. Therefore I understand my account will be charged $50.00 for each cancellation without a24 hour notice.

Patient's full name ___«SD_PAT_1->FullName»___

Guarantor Signature______________________________________________ Date: ____________________

Print name of Guarantor___«SD_PAT_1->Acct->G1TtlAndName»_

**SIGNATURE ON FILE**_________________________________________________________________

I hereby authorize payment directly to **Coconut Grove Smile**., P.A. of the dental benefits
Otherwise payable to me.

Signature (insured Person) ____________________________________________________________
Signature is valid for two years from the above date, unless revoked by me at an earlier date.

**Coconut Grove Smile**.is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

**Patient's Signature:** _________________________________________________________________

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## 24 HOURS CANCELLATION & "NO SHOW" FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care there for, **Coconut Grove Smile** reserves the right to charge a fee of $50.00 for all missed appointments (no shows) and appointments which, absent a compelling reason, are not cancelled with a 24 hour advance notice.

Thank you for understanding and cooperation as we strive to best serve the needs of fall of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Credit Card Information

Card Type: ( ) MasterCard ( ) Visa ( ) Discover ( ) AMEX

( ) Other

Cardholder Name: ___________________________________________

Card Number: ______________________________________________

Expiration Date: ____________________________________________

Security Code: __________________

Cardholder Zip Code: _____________

I authorized Coconut Grove Smile to charge my card for the reasons described upon

Patient's name___________________________________________________

Patient's Signature_______________________________________________

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