

REGISTRATION
(PLEASE PRINT)

ANASTASIA DENTAL ASSOCIATES

3534 A1A South
St. Augustine Beach, FL 32080
(904) 461-5788

Home Phone: _____

Cell Phone: _____

E-mail: _____

Date _____

www.anastasiadental.com

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

PRIMARY INSURANCE

Person Responsible for Account _____ Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ Name of Insurance Company(ies)
and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND
CONSENT OF RELEASE OF HEALTH INFORMATION**

You May Refuse to Sign This Acknowledgement

I acknowledge that I have read a copy of the currently effective Notice of Privacy Practices for Anastasia Dental Associates. I also understand that the purpose of the Notice of Privacy Practices is to inform me that no personal information will be released without my consent and that I do consent to the release of my personal information to insurance companies and other doctors, dentists, and other personnel in the normal course of my treatment and only as necessary as detailed in the Notice of Privacy Practices.

Signature

Date

MEDICAL HISTORY

Answer all questions by checking YES or NO and fill the blank spaces when indicated.

Answer to the following questions are for our records only and are confidential.

1. My last medical physical examination was on (approximate) _____
 2. The name and address of my personal physician is _____
 3. Are you under the care of a physician? Yes No
If so, what is the condition being treated? _____
 4. List any serious illnesses or operations. _____
 5. Do you have or have you had any of the following diseases or problems?
 - a) Heart abnormalities present since birth Yes No
 - b) Cardiovascular disease (heart trouble, heart attack, angina, stroke, high blood pressure, heart murmur) Yes No
 - c) Asthma or lung disease Yes No
 - d) Fainting spells or seizures Yes No
 - e) Diabetes Yes No
 - f) Hepatitis, jaundice or liver disease Yes No
 - g) Arthritis or other joint problems Yes No
 - h) Stomach ulcers Yes No
 - i) Kidney trouble Yes No
 - j) Tuberculosis Yes No
 - k) Venereal disease Yes No
 - l) AIDS or HIV+ Yes No
 - m) Bleeding or blood disorder Yes No
 - n) Other (list) _____ Yes No
 6. Are you or have you ever taken medication for treatment of osteoporosis? Yes No
 7. Do you have or have you had any tumors or cancer?
 - a) If yes, have you had any surgery or radiation treatment to your head or neck? Yes No
 8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No
 9. Are you taking any drugs or medication? List any medication you are taking. _____
 10. Are you allergic or have you reacted adversely to
 - a) Local Anesthetics (NOVOCAINE) Yes No
 - b) Penicillin or other antibiotics Yes No
 - c) Sulfu drugs Yes No
 - d) Aspirin Yes No
 - e) Codeine or other narcotics Yes No
 - f) Other _____ Yes No
 11. Have you had any serious trouble associated with any previous dental treatment? If so, explain _____
 12. Do you have any disease, condition or problem not listed above that you think I should know about? If so, explain _____
 13. Are you pregnant or have you recently missed a menstrual period? Yes No
 14. Are you presently breastfeeding? Yes No
 15. Are you taking oral contraceptives? Yes No
- Chief dental complaint (Why did you come to the office today?): _____
- Signature of Patient (verifying information) _____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study notes, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____