

HIGH QUALITY DENTAL CARE

- Thorough exams
- Gentle cleanings
- Nonsurgical gum care
- Tooth whitening
- Dental implants
- Full and partial dentures
- Denture relines and repairs
- Crowns and bridges
- Bonding and veneers
- Tooth-colored fillings
- Extractions
- Root canals
- Sealants

AFFORDABLE & CONVENIENT

- Early Morning and evening appointments
- Immediate care if you hurt
- Flexible payment plans
- Most insurance accepted
- Visa and MasterCard honored

Dear New Patient,

A very warm welcome to you. The entire team would like to thank you for selecting our office to care for your dental needs. We are committed to providing each patient with the highest quality dental care in a gentle, efficient, and pleasant manner and to strongly encourage prevention of future dental problems.

Generally, the first visit will include a thorough examination and, if necessary, x-rays for proper diagnosis, followed by a consultation of your dental needs. So that you will fully understand your financial responsibilities, treatment costs will be discussed and payment arrangements can be made.

To insure that your visit is as comfortable as possible, we ask that you please complete both sides of the enclosed patient registration forms and bring them with you ten minutes before your scheduled appointment. Also, if you are covered by dental insurance, in order that your claims are processed in a timely manner, please bring in your dental insurance card.

Should you have any questions, please feel free to call at your convenience. Our team is looking forward to meeting you.

Sincerely,

Frank J. Vascimini, D. D. S., P. A. and Team

FRANK J. VASCIMINI, DDS

Fellow: Academy of General Dentistry Diplomate: International Congress of Oral Implantology Master: American Academy of Implant Prosthodontics

Member: American Dental Association, American Academy of Cosmetic Dentistry, Florida Academy of General Dentistry,

West Coast Dental Association, American College of Oral Implantology, American Society of Osseointegration

Patient Name			

Patient Account No.

DENTAL HISTORY

Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

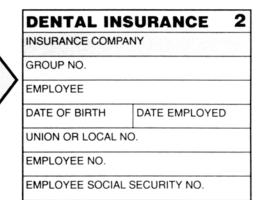
Date of last Dental visit Last D	ental Cl	eaning	Last Full Mouth X-rays		
Previous Dentist's Name					
Address			State Zip _		
Telephone					
How often do you have dental examinations?					
How often do you brush your teeth?			How often do you floss?		
What other dental aids do you use? (Interplak, toothpi	ck, etc.)				
Do you have any dental problems now?	Yes	No			
f yes, please describe:					
Are any of your teeth sensitive to:			Have you ever had:		
Hot or Cold?	Yes	No	Orthodontic treatment?	Yes	N
Sweets?	Yes	No	Oral Surgery?	Yes	N
Biting or Chewing	Yes	No	Periodontal treatment?	Yes	Ν
Have you noticed any mouth odors or bad tastes?	Yes	No	Your teeth ground or the bite adjusted?	Yes	N
Do you frequently get cold sores, blisters,	Voc	No.	A bite plate or mouth guard?	Yes	N
or any other oral lesions?	Yes	No	A serious injury to the mouth or head? If so, please describe, including cause	Yes	N
Do your gums bleed or hurt?	Yes	No			
Have your parents ever experienced gum disease					
or tooth loss?	Yes	No	Have you experienced:	.,	
Have you noticed any loose teeth or change	Voc	No	Clicking or popping of the jaw?	Yes	N
in your bite? Does food tend to become caught in between	Yes	No	Pain? (joint, ear, side of face) Difficulty in opening or closing the mouth?	Yes Yes	No No
your teeth?	Yes	No	Difficulty in chewing on either side of the mouth?	Yes	N
If yes, where?			Headaches, neckaches or shoulder aches?	Yes	N
, , , , , , , , , , , , , , , , , , , ,			Sore muscles (neck, shoulders)?	Yes	Ν
Do you:					
Clench or grind your teeth while awake or asleep?	Yes	No	Are you satisfied with your teeth's appearance?	Yes	N
Bite your lips or cheeks regularly?	Yes	No	Would you like to keep all of your teeth all of your life? Do you feel nervous about having dental treatment?	Yes	N
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No	If so, what is your biggest concern?	Yes	N
Mouth breathe while awake or asleep?	Yes	No			
Have tired jaws, especially in the morning?	Yes	No	0,		
Smoke/chew tobacco?	Yes	No	Have you ever had an upsetting dental experience? If yes, please describe	Yes	N
is there anything else about having dental treatmen	t voli wo	uld like	e to let us know?	Yes	N

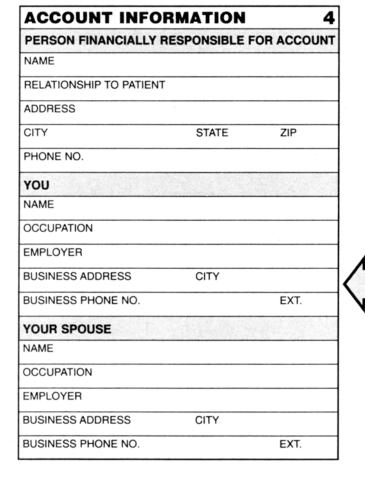
Have you been under the care of a medical do If yes, for what? Physician's Name Address Have you taken any medication or drugs durin Are you taking any medication, drugs or pills n If yes, please list name and dosage Are you aware of having an allergic (or adv If yes, please list: Have you been a patient in the hospital during Indicate which of the following you have had, of Heart (Surgery, Disease, Attack) Yes No Chest Pain
If yes, for what? Physician's Name Address Have you taken any medication or drugs durin Are you taking any medication, drugs or pills n If yes, please list name and dosage Are you aware of having an allergic (or adv If yes, please list: Have you been a patient in the hospital during Indicate which of the following you have had, of Heart (Surgery, Disease, Attack) Yes No Chest Pain
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If yes, please list: Have you been a patient in the hospital during Indicate which of the following you have had, or Heart (Surgery, Disease, Attack) Yes No Chest Pain
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Have you been a patient in the hospital during Indicate which of the following you have had, on the Heart (Surgery, Disease, Attack) Yes No Chest Pain
Indicate which of the following you have had, of Heart (Surgery, Disease, Attack) Yes No Chest Pain
Heart (Surgery, Disease, Attack) Yes No Chest Pain Yes No
Chest Pain Yes No
Congenital Heart Disease
High Blood Pressure Yes No
Mitral Valve Prolapse
Artificial Heart Valve
Heart Pacemaker Yes No
Rheumatic Fever Yes No
Arthritis/Rheumatism Yes No
Cortisone Medicine Yes No
Swollen Ankles Yes No
Stroke Yes No
Diet (Special/Restricted) Yes No
Artificial Joints (hip, knee, etc.) Yes No
Kidney Trouble Yes No
Do you use more than two pillows to sleep?
Have you lost or gained more than ten pounds
Do you have or have you had any disease, co
If yes, please list:
Women. Are you: Pregnant? Yes, _ Munderstand the above information is new have answered all questions to the best my permission to ask the respective heal will notify the doctor of any change in many c
atient/Guardian Signature
No N

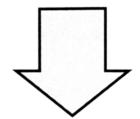
	DATE					
N	NAME					
IF THIS	SPOUSE					
APPOINTMENT IS FOR YOU	ADDRESS					
START HERE	CITY		STATE	ZIP		
\neg	HOME PHONE I	NO.	CELL PHONE NO.			
,	EMAIL ADDRES	S				
	BIRTHDATE	AGE	MALE	FEMALE		
	MARRIED	SINGLE	DIVORCED	WIDOWED		
	SOCIAL SECUR	ITY NO.				
N	DATE					
IF THIS	NAME					
APPOINTMENT IS FOR YOUR CHILD	ADDRESS					
START HERE	CITY		STATE	ZIP		
$\neg V$	HOME PHONE	NO.	CELL PHONE NO.			
,	EMAIL ADDRESS					
	BIRTHDATE	AGE	MALE	FEMALE		
	SCHOOL		-	GRADE		
	SOCIAL SECURITY NO.					
	IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO					

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION







	GETTING TO KNO	W YOU	3
	IS ANOTHER MEMBER OF YOU AT OUR OFFICE?	R FAMILY OR	RELATIVE A PATIENT
	NAME:	RELATIONS	HIP:
	REFERRED TO US BY		
	PERSON TO CONTACT FOR EM	IERGENCY	
	PHONE NUMBER		
1	ADDRESS		
1	CITY	STATE	ZIP
	CLOSEST RELATIVE NOT LIVIN	IG WITH YOU	
	PHONE NUMBER		
	ADDRESS		
	CITY	STATE	ZIP
	YOUR FORMER ADDRESS		
	CITY	STATE	ZIP

CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use my protected health information to carry out:

- Treatment (including indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I also understand that by signing this consent, I authorize you to use my general information to carry out:

- Calling me to confirm my appointments at the office, remind me to take any necessary medication before an appointment, or to follow up with me after large treatment;
- Mailing out post cards to remind me to schedule my next appointment

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient	Date
Parent or responsible Party	Relationship to Patient