

WELCOME TO THE PRACTICE OF

Dr. Marcel Gegati D.M.D

We are so glad that you have scheduled your new patient appointment in our office. Enclosed you will find your New Patient health history form, as well as your HIPPA information sheet. Please complete all forms and return them to us at your scheduled appointment. We look forward to meeting you.

Any insurance information you can provide me with ahead of time would be greatly appreciated. It will allow me time to verify your coverage, and this will assist you with information for your upcoming appointment. It will also help you in scheduling for any dental services you may need in the future.

If you have any questions, or need directions to our office please contact us at: 954-792-4100

Our Address is:
300 NW 70th Ave., Suite 108
Plantation, Fl 33317

For additional information please visit our website.
www.confident-smiles-designs.com

Sincerely,

Joanne Wieggers
Office Coordinator

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Ever taken fen-phen? * _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
[] Aspirin [] Penicillin [] Codeine [] Acrylic [] Metal [] Latex Rubber [] Other _____
Women (Please check): [] Pregnant/trying to get pregnant [] Nursing [] Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

Table with 4 columns of conditions and Yes/No checkboxes. Conditions include Heart Trouble/Disease, Bruise Easily, Emphysema, Yellow Jaundice, etc.

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Table with columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, REVIEWED BY. Includes rows for None and Dr. signatures.

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NOTICE OF PRIVACY PRACTICES

When you sign this document, you signify that you agree that we can and will use and disclose your health information to treat you, obtain payment for services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated, sought payment for services or perform health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our notice of Privacy Practice, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our notice of Privacy Practices describes how to ask for restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Signature

Date

IF YOU ARE SIGNING AS A PERSONAL REPRESENTATIVE OF THE PATIENT, DESCRIBE YOUR RELATIONSHIP TO THE PATIENT AND THE SOURCE OF YOUR AUTHORITY TO SIGN.

Relationship to Patient

Print Name

Source of Authority