REGISTRATION
(PLEASE PRINT)

Anastasia Dental
ASSOCIATES
3534 A1A South
St. Augustine Beach, FL 32080
(904) 461-5788
www.anastasiadental.com

Home Phone:_____

Cell Phone:_____

Date: _____

E-mail:_____

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 (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

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT OF RELEASE OF HEALTH INFORMATION

You May Refuse to Sign This Agreement

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 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

Anastasia Dental Associates
3534 A1A South
Saint Augustine Beach, FL 32080
Phone: 904-461-5788
Fax: 904-517-8384

MEDICAL HISTORY

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

Answers 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? ☐ Yes ☐ No
   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. _____

_____

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MEDICAL HISTORY

10. Are you allergic or have you reacted adversely to

a) Local Anesthetics (NOVOCAINE)	☐ Yes	☐ No
b) Penicilline or other antibiotics	☐ Yes	☐ No
c) Sulfa 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% financial 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_____

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