The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain optimum dental health. Please fill out this confidential form completely. The better we communicate, the better we can care for you.

ABOUT YOU 1

Today's Date ______

PATIENT'S NAME ______

I prefer to be called ______

Male ______ Female ______

Single ______ Married ______ Divorced ______ Widowed ______ Separated ______

Birth Date ______ / ______ / ______ Age ______

SS# ______

HOME ADDRESS ______

______

City ______ State ______ Zip ______

TELEPHONE NUMBERS

Hm # ______ Cell# ______

Wk # ______ Other ______

Email ______

Preferred Contact # ❑ Home ❑ Work ❑ Cell ❑ Other

EMPLOYER ______

Employer's Address ______

______

Occupation ______ How long: ______

SPOUSE INFORMATION

His/Her Name ______

Employer ______

Wk # ______ SS # ______

Birth Date ______ / ______ / ______

PRIMARY DENTAL INSURANCE 2

Insurance Co. ______

Ins. Address ______

City ______ State ______ Zip ______

Ins. Phone # ______

Group # ______

Insured's Name ______

Ins. Birthday ______

Ins. ID # ______

Ins. Employer ______

Address ______

City ______ State ______ Zip ______

SECONDARY DENTAL INSURANCE

Insurance Co. ______

Ins. Address ______

City ______ State ______ Zip ______

Ins. Phone # ______

Group # ______

Insured's Name ______

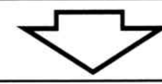
Ins. Birthday ______

Ins. ID # ______

Ins. Employer ______

Address ______

City ______ State ______ Zip ______



GETTING TO KNOW YOU 3

Whom may we thank for referring you? ______

______

Other family members seen by us. ______

______

Previous dentist ______

Person to contact for emergency ______

______ Phone ______

ACCOUNT INFORMATION 4

Person responsible for account

His/Her Name ______

Wk # ______ Hm # ______

Address: ______

City ______ State ______ Zip ______

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize Dr. Castellanos / Dr. Slaybaugh to furnish information to my insurance company concerning my care. I further hereby assign all payments for dental services rendered to me, or my dependents, by the above insurance company. I understand that I am fully responsible for any portion of those services not covered by my insurance benefits.

Date ______ Signature of Authorized Person ______

Patient's name ______________________________

I understand that it is my responsibility to disclose and update Dr. Castellanos / Dr. Slaybaugh of any changes in my medical history or medications taken prior to each appointment. I understand that Dr. Castellanos / Dr. Slaybaugh may not be able to treat my chief complaint due to my medical history. I understand that Dr. Castellanos / Dr. Slaybaugh will not be held liable for my failure to do above. I confirm that the below medications and information regarding how the medications are being taken is correct and will inform Dr. Castellanos / Dr. Slaybaugh of changes in my medical history and medications. **Patient or Legal Guardian's Initials** __________

I. CHECK APPROPRIATE ANSWER (Leave blank if you do not understand)

1. Is your general health good? .... ☐Y ☐N
2. Has there been a change in your health within the last year? .... ☐Y ☐N
   If yes, what? ______________________________
3. Have you been hospitalized or had a serious illness in the past year? .... ☐Y ☐N
   If yes, why? ______________________________
4. Are you being treated by a physician now? .... ☐Y ☐N
   If yes, for what? ______________________________
   Date of last physical exam __________ Date of last dental exam if performed in another dental office __________
   Physicians Name ______________________________ Physicians Phone # __________
5. Do you feel very nervous about having dental treatment? .... ☐Y ☐N
6. Have you ever had a bad experience in the dental office? .... ☐Y ☐N
7. Are you in pain now? .... ☐Y ☐N

II. HAVE YOU EXPERIENCED:

1. Chest pain (Angina)? .... ☐Y ☐N
2. Swollen ankles? .... ☐Y ☐N
3. Shortness of breath? .... ☐Y ☐N
4. Recent weight loss, fever, night sweats? .... ☐Y ☐N
5. Persistent cough, coughing up blood? .... ☐Y ☐N
6. Bleeding problems, bruising easily? .... ☐Y ☐N
7. Sinus problems? .... ☐Y ☐N
8. Difficulty swallowing? .... ☐Y ☐N
9. Diarrhea, constipation, blood in stools? .... ☐Y ☐N
10. Frequent vomiting? .... ☐Y ☐N
11. Difficulty urinating, blood in urine? .... ☐Y ☐N
12. Dizziness? .... ☐Y ☐N
13. Ringing in ears? .... ☐Y ☐N
14. Headaches? .... ☐Y ☐N
15. Fainting spells? .... ☐Y ☐N
16. Blurred vision? .... ☐Y ☐N
17. Seizures? .... ☐Y ☐N
18. Excessive thirst? .... ☐Y ☐N
19. Frequent urination? .... ☐Y ☐N
20. Dry mouth? .... ☐Y ☐N
21. Jaundice? .... ☐Y ☐N
22. Joint pain, stiffness? .... ☐Y ☐N

III. DO YOU HAVE OR HAVE YOU HAD:

1. Heart disease, heart defects, artificial heart valve? .. ☐Y ☐N
2. Heart attack? .... ☐Y ☐N
   If yes, when? __________
3. Congestive heart failure? .... ☐Y ☐N
4. Heart Murmur? .... ☐Y ☐N
5. Rheumatic fever? .... ☐Y ☐N
6. Stroke, hardening of arteries? .... ☐Y ☐N
   If yes, when? __________
7. High blood pressure? .... ☐Y ☐N
   If yes, when were you diagnosed? __________
   What is your usual reading? __________
   How often do you see your doctor for checkup? __________
8. Asthma, Tuberculosis, Emphysema, COPD? .. ☐Y ☐N
   How often do you see your physician? __________
9. Sleep apnea? .... ☐Y ☐N
10. Hepatitis, other liver disease? .... ☐Y ☐N
11. Stomach problems, ulcers? .... ☐Y ☐N
12. Family history of diabetes, heart problems, tumors? .... ☐Y ☐N
13. HIV / AIDS? .... ☐Y ☐N
14. Tumors, cancers? .... ☐Y ☐N
    If yes, what type? __________ when? __________
    Treating Doctor/Hospital __________
    Are you currently undergoing chemotherapy? ☐Y ☐N
    Date last chemotherapy taken __________
    Did you have radiation in the area of the head/neck? ☐Y ☐N
15. Arthritis, rheumatism? .... ☐Y ☐N
16. Eye disease? .... ☐Y ☐N
17. Skin disease? .... ☐Y ☐N
18. Anemia? .... ☐Y ☐N
19. Hemophilia? .... ☐Y ☐N
20. VD (syphilis or gonorrhea)? .... ☐Y ☐N
    Herpes? .... ☐Y ☐N
21. Sickle cell disease? .... ☐Y ☐N
22. Kidney, bladder disease? .... ☐Y ☐N
23. Thyroid, adrenal disease? .... ☐Y ☐N
24. Diabetes? .... ☐Y ☐N
    If yes, What type? __________
    Are you controlled? __________
    Sugar level when tested? __________
    How often do you check levels? __________

IV. DO YOU HAVE OR HAVE YOU HAD:

1. Psychiatric care? ☐ Y ☐ N
2. Radiation treatments? ☐ Y ☐ N
3. Chemotherapy? ☐ Y ☐ N
4. Prosthetic heart valve? ☐ Y ☐ N
5. Hospitalization? ☐ Y ☐ N
6. Blood transfusions? ☐ Y ☐ N
7. Surgeries? ☐ Y ☐ N
8. Pacemaker? ☐ Y ☐ N
9. Contact lenses? ☐ Y ☐ N
10. Artificial joints? ☐ Y ☐ N
    If yes, what joints? ______________
    When? ______________
    Were you instructed to take pre-medications? ☐ Y ☐ N

V. ARE YOU TAKING:

1. Recreational drugs? ☐ Y ☐ N
2. Drugs medications, over the counter medicines (including Aspirin) or natural remedies? ☐ Y ☐ N
3. Tobacco in any form? ☐ Y ☐ N
4. Alcohol? ☐ Y ☐ N
5. Blood thinners? ☐ Y ☐ N
   Coumadin/Warfarin, Heparin/Lovenox, Plavix, Xarelto, Aspirin? ☐ Y ☐ N
   If yes, how long on medication? ______________
   Why on medication? ______________
   Last time you have seen prescribing Doctor? ______________

Please list all medications or natural remedies below in section VIII.

VI. WOMEN ONLY:

1. Are you or could you be pregnant or nursing? ☐ Y ☐ N
2. Taking birth control? ☐ Y ☐ N

VII. ALL PATIENTS:

1. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ☐ Y ☐ N
2. Have you lost or gained more than 10 pounds in the past year? ☐ Y ☐ N
3. Do you ever wake up from sleep short of breath? ☐ Y ☐ N
4. Do you or have you had any other disease or medical problem NOT listed on this form? ☐ Y ☐ N
   If so, please explain: ______________

VIII. IF YOU ARE TAKING MEDICATIONS, PLEASE LIST:

Name of Medication	Dose	Directions	How Long on Medication

1. Are you allergic or have you reacted adversely to any of the following substances: (Please check if Y) ☐ Y ☐ N
   ☐ Local Anesthetic ☐ Aspirin or Ibuprofen ☐ Valium ☐ Penicillin/Amoxicillin ☐ Scopolamine
   ☐ Codeine or other narcotics ☐ Latex ☐ Iodine ☐ Other Antibiotics
2. Are you aware of being allergic to any other medication or substance not listed? ☐ Y ☐ N
3. PLEASE DESCRIBE YOUR REACTION TO THE ALLERGEN: ______________

CONSENT:

I certify the above information is true to the best of my knowledge. The undersigned hereby authorizes Dr. Castellanos / Dr. Slaybaugh to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Castellanos / Dr. Slaybaugh to make a thorough diagnosis of the patient's dental needs.

PATIENT ______________ DATE ______________ WITNESS ______________

Parent or Responsible Party ______________ Relationship to Patient ______________

Daniel S. Slaybaugh, D.M.D
E. Mauricio Castellanos, D.D.S.
28467 U.S. 19 North, Suite 301
Clearwater, Florida 33761

PATIENT CONSENT FORM

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 and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

-Treatment (including direct or 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 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.

Signed this______day of______________, 20____ .

Print Patient Name:_________________________________

Relationship to Patient:______________________________

Signature:_______________________________________

Communications Update Form

"Communication is the Key." We've all heard that, but in our practice, communications is critical in taking excellent care of you and your family. In the interest of making sure we are doing the right things right, please take a moment to update your information. Thank you for helping us help you.

Daniel S. Slaybaugh, DMD & Staff

Name: ______________________________

Email: ______________________________

Cell Phone #: _________________________

Home Phone #: ________________________

* this information will be used for automated, email & text confirmation reminders

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- Occasionally, in certain circumstances, it is necessary to discuss your treatment, financial arrangements, or other healthcare needs with a relative or friend. Please designate with whom it may be appropriate to discuss your care:

[ ] Spouse ____________________ [ ] Children ____________________

[ ] Relative ____________________ [ ] Friends/Caregiver ________________

[ ] Other ____________________ [ ] Parent ____________________

Please sign and date: _________________________ _______________

Signature Date