

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. Thank you.

| | |
|---|--|
| <p style="text-align: center;">ABOUT YOU</p> <p>Today's Date: _____</p> <p>PATIENTS NAME: _____</p> <p>Preferred name: _____</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated</p> <p>Date of Birth: ____/____/____ Age: _____</p> <p>SS#: _____</p> <p>HOME ADDRESS: _____</p> <p>City _____ State _____ Zip _____</p> <p>TELEPHONE NUMBERS:</p> <p>Hm#: _____ Cell#: _____</p> <p>WK#: _____ Other: _____</p> <p>Email: _____</p> <p>Preferred Contact #: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Other</p> <p>EMPLOYER: _____</p> <p>Employer's Address: _____</p> <p>City _____ State _____ Zip _____</p> <p>Occupation: _____ How Long: _____</p> | <p style="text-align: center;">PRIMARY DENTAL INSURANCE</p> <p>Insurance Company: _____</p> <p>Insurance Address: _____</p> <p>City _____ State _____ Zip _____</p> <p>Insurance Phone #: _____</p> <p>Group #: _____</p> <p>Insured's Name: _____</p> <p>Insured's Date of Birth: ____/____/____</p> <p>Insured's ID #: _____</p> <p>Insured's Employer: _____</p> <p>Address: _____</p> <p>City _____ State _____ Zip _____</p> |
| <p style="text-align: center;">SPOUSE INFORMATION</p> <p>Name: _____</p> <p>Employer: _____</p> <p>Wk#: _____</p> <p>SS#: _____</p> <p>Date of Birth: ____/____/____ Age: _____</p> | <p style="text-align: center;">SECONDARY DENTAL INSURANCE</p> <p>Insurance Company: _____</p> <p>Insurance Address: _____</p> <p>City _____ State _____ Zip _____</p> <p>Insurance Phone #: _____</p> <p>Group #: _____</p> <p>Insured's Name: _____</p> <p>Insured's Date of Birth: ____/____/____</p> <p>Insured's ID #: _____</p> <p>Insured's Employer: _____</p> <p>Address: _____</p> <p>City _____ State _____ Zip _____</p> |
| <p style="text-align: center;">ACCOUNT INFORMATION</p> <p>Person Responsible for account</p> <p>Name: _____</p> <p>Work#: _____ Hm#: _____</p> <p>Address: _____</p> <p>City _____ State _____ Zip _____</p> | <p style="text-align: center;">GETTING TO KNOW YOU</p> <p>Whom may we thank for referring you?: _____</p> <p>Other family members seen by us?: _____</p> <p>Previous dentist: _____</p> <p>Emergency Contact Name: _____</p> <p>Phone Number: _____</p> |

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize Dr. Daniel S. Slaybaugh to provide 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 to Dr. Daniel S. Slaybaugh. 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: _____ Date: _____

I understand that it is my responsibility to disclose and update Dr. Slaybaugh of any changes in my medical history or medications taken prior to each appointment. I understand that Dr. Slaybaugh may not be able to treat my chief complaint due to my medical history. I understand that 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. 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 <input type="checkbox"/> N <input type="checkbox"/> | 12. Dizziness? Y <input type="checkbox"/> N <input type="checkbox"/> |
| 2. Swollen ankles?..... Y <input type="checkbox"/> N <input type="checkbox"/> | 13. Ringing in ears?..... Y <input type="checkbox"/> N <input type="checkbox"/> |
| 3. Shortness of breath? Y <input type="checkbox"/> N <input type="checkbox"/> | 14. Headaches?..... Y <input type="checkbox"/> N <input type="checkbox"/> |
| 4. Recent weight loss or gain, fever, night sweats? Y <input type="checkbox"/> N <input type="checkbox"/> | 15. Fainting spells?..... Y <input type="checkbox"/> N <input type="checkbox"/> |
| 5. Persistent cough, coughing up blood?..... Y <input type="checkbox"/> N <input type="checkbox"/> | 16. Blurred vision?..... Y <input type="checkbox"/> N <input type="checkbox"/> |
| 6. Bleeding problems, bruising easily?..... Y <input type="checkbox"/> N <input type="checkbox"/> | 17. Seizures? Y <input type="checkbox"/> N <input type="checkbox"/> |
| 7. Sinus problems? Y <input type="checkbox"/> N <input type="checkbox"/> | 18. Excessive thirst?..... Y <input type="checkbox"/> N <input type="checkbox"/> |
| 8. Difficulty swallowing?..... Y <input type="checkbox"/> N <input type="checkbox"/> | 19. Frequent urination?..... Y <input type="checkbox"/> N <input type="checkbox"/> |
| 9. Diarrhea, constipation, blood in stools?..... Y <input type="checkbox"/> N <input type="checkbox"/> | 20. Dry mouth?..... Y <input type="checkbox"/> N <input type="checkbox"/> |
| 10. Frequent vomiting? Y <input type="checkbox"/> N <input type="checkbox"/> | 21. Jaundice?..... Y <input type="checkbox"/> N <input type="checkbox"/> |
| 11. Difficulty urinating, blood in urine?..... Y <input type="checkbox"/> N <input type="checkbox"/> | 22. Joint pain, stiffness?..... Y <input type="checkbox"/> N <input type="checkbox"/> |

III. DO YOU HAVE OR HAVE YOU HAD:

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

- 6. Surgeries? Y N
- 7. Pacemaker? Y N
- 8. Contact lenses? Y N
- 9. 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,
shortness of breath, or because you are tired? Y N
- 2. 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 authorize Dr. Slaybaugh to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Slaybaugh to make a thorough diagnosis of the patient's dental needs.

PATIENT: _____ **DATE:** _____ **DOCTOR/WITNESS:** _____

Parent or Responsible Party: _____ **Relationship to Patient:** _____

Name _____

Please check "Yes" or "No" as applicable to all below:

- Have you had complications from past dental treatment? Y N
- Have you had trouble getting numb? Y N
- Have you had/have braces, orthodontic treatment? Y N
- Do you experience dry mouth? Y N
- Are any teeth sensitive to hot, cold, biting, sweets or do you avoid brushing any part of your mouth?... Y N
- Does food get trapped between any teeth?..... Y N
- Have you ever whitened or bleached your teeth? Y N
- Have you experienced popping and/or clicking of your jaw joint?..... Y N
- Doyou have difficulty chewing?..... Y N
- Doyou clench or grind your teeth?..... Y N
- Doyou wear or have worn a bite appliance? Y N
- Do your gums bleed when brushing or flossing?..... Y N
- Have you been treated for gum disease or told you have lost bone around your teeth? Y N
- Have you noticed an unpleasant taste or odor in your mouth? Y N
- Have you experienced gum recession? Y N
- Have any teeth become loose on their own (without injury)? Y N
- Have you experienced a burning sensation in your mouth? Y N
- Doyou snore or wake up frequently during the night? Y N

If any of the checked boxes need further explanation, please describe:

Daniel S. Slaybaugh, D.M.D
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**

-
- **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**