

# PATIENT REGISTRATION AND MEDICAL HISTORY

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient \_\_\_\_\_

LAST NAME

FIRST NAME

MIDDLE INITIAL

PREFERRED NAME

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  Male  Female Age \_\_\_\_\_ DOB \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_ Spouse Parent Birthdate \_\_\_\_\_

Spouse/Parent Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse/Parent Social Security # \_\_\_\_\_

Name of Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

In Case of Emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

Whom many we thank for referring you? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last Physical \_\_\_\_\_

Have you ever had any of the following? (Check all boxes that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart Murmur                   | <input type="checkbox"/> Epilepsy                             | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Headaches                            | <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> Low Blood Pressure             | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Swollen neck glands |
| <input type="checkbox"/> Circulatory Problems           | <input type="checkbox"/> Excess alcohol consumption           | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Nervous Problems               | <input type="checkbox"/> Psychiatric Care                     | <input type="checkbox"/> Sinus Problems      |
| <input type="checkbox"/> Radiation Treatment            | <input type="checkbox"/> Mitral Valve Prolapse                | <input type="checkbox"/> AIDS/HIV            |
| <input type="checkbox"/> Artificial Heart Valves/Joints | <input type="checkbox"/> Allergies to Anesthetics             | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Recent Weight Loss             | <input type="checkbox"/> Allergies to medicines or drugs      | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> General Allergies                    | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Blood Disease                        | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Respiratory Disease            | <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Hemophilia                     | <input type="checkbox"/> Currently taking Bisphosphonates     |  |

Do you have allergies or have you ever had an adverse reaction to any medication? \_\_\_\_\_ If so, what \_\_\_\_\_

Have you ever responded adversely to medical or dental treatment? \_\_\_\_\_

Are you taking medication at this time? \_\_\_\_\_ If so, what? \_\_\_\_\_

Are you under the care of a physician? \_\_\_\_\_ For what conditions? \_\_\_\_\_

If patient is a child, what is his or her weight? \_\_\_\_\_ (Women) Do you suspect that you are pregnant? \_\_\_\_\_ Are you nursing? \_\_\_\_\_

Is there anything else we should know about your medical history? \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Dentist Signature: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance with \_\_\_\_\_

Name of Insurance Company (ies)

And assign directly to Dr. \_\_\_\_\_ all 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 my insurance submissions whether manual or electronic.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**MINOR/CHILD CONSENT**

I, being the parent or guardian of \_\_\_\_\_ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**FINANCIAL AGREEMENT**

I acknowledge that payment is due at the time of treatment for all procedures, unless other arrangements have been made in writing. All prosthetic services are considered completed after a decisive appointment has been rendered. The decisive appointment for full/partial dentures, crown & bridge, and other prosthetic services is the date the final impression was performed. The decisive appointment for root canal therapy is the date the canal is opened. I agree to give my insurance carrier permission to pay in full for all procedures which have reached decisive appointment. I agree that parent/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**MEDICAL HISTORY UPDATE (to be completed on subsequent visits)**

Have there been any changes in your health since your last dental appointment?  No  Yes, for what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Dentist Signature: \_\_\_\_\_

Have there been any changes in your health since your last dental appointment?  No  Yes, for what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Dentist Signature: \_\_\_\_\_

Have there been any changes in your health since your last dental appointment?  No  Yes, for what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Dentist Signature: \_\_\_\_\_

# DENTAL HISTORY

1. Reason for today's visit? \_\_\_\_\_

2. Name of your previous Dentist \_\_\_\_\_ Phone \_\_\_\_\_

3. Address of your previous Dentist \_\_\_\_\_

4. Date of your last dental visit \_\_\_\_\_ and last x-rays \_\_\_\_\_

5. Are you completely satisfied with your smile? Explain \_\_\_\_\_

6. How many times a day do you brush your teeth? \_\_\_\_\_

7. Do you use dental floss regularly? \_\_\_\_\_  Yes  No

8. Do your gums bleed or hurt when you brush them? \_\_\_\_\_  Yes  No

9. Do you feel you have bad breath? \_\_\_\_\_  Yes  No

10. Do any of your teeth feel loose? \_\_\_\_\_  Yes  No

11. Do you have a tooth ache? \_\_\_\_\_  Yes  No

12. Are your teeth sensitive to heat, cold, sweets? \_\_\_\_\_  Yes  No

If so, explain \_\_\_\_\_

13. Do you clench, or grind your teeth during the day or at night? \_\_\_\_\_  Yes  No

14. Does your jaw click or pop when chewing? \_\_\_\_\_  Yes  No

15. Do you have any jaw pain? \_\_\_\_\_  Yes  No

16. Do you have frequent headaches? \_\_\_\_\_  Yes  No

17. Does food collect between your teeth? \_\_\_\_\_  Yes  No

18. Do you snore while sleeping? \_\_\_\_\_  Yes  No

## FOR PARENTS

19. Does your child suck his or her thumb? \_\_\_\_\_  Yes  No

20. Does your child go to sleep with a bottle in his mouth; do you use the bottle as a pacifier?  Yes  No

I certify that the above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Dental Wellness of Palm Beach

MIGUEL R. GRILLO, D.D.S., P.A.  
(561) 290-0744 • Fax: (561) 290-0368  
3540 Forest Hill Blvd.  
WPB, FL 33406

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## BROKEN APPOINTMENT AGREEMENT

I, \_\_\_\_\_ am aware that there is a broken appointment fee for any appointments that I either **miss, change or cancel without a 24 hour notice**. I understand that this time has been reserved for my personal dental needs.

The fees are as follows:

1. General dentist appointment: \$30 per half hour/\$60 per hour
2. Hygienist: \$30 per half hour/\$60 per hour
3. Orthodontic treatment: \$30 per appointment
4. Osseous Surgery: \$200 per visit
5. Scaling & Root Planning: \$ 75 per visit
6. Periodontal maintenance: \$50

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT)

I, \_\_\_\_\_ have received and read a copy of this office's  
Notice of Privacy Practice.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

*If you are a legal representative of the patient, please print the patient's name and describe your  
authority:*

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### Office Use Only

As a privacy officer, I attempted to obtain the patient's (or representatives) signature on this  
acknowledgement but did not because:

\_\_\_\_\_ It was emergency treatment

\_\_\_\_\_ I could not communicate with the patient

\_\_\_\_\_ The patient refused to sign

\_\_\_\_\_ The patient was unable to sign because: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

Signature of Privacy officer \_\_\_\_\_



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SEXTANT

UPPER			
LOWER			

## PERIODONTAL POCKET PROBING EXAMINATION INFORMED CONSENT

In order to perform a comprehensive intra-oral examination, it is necessary to probe each natural tooth. Radiographs (x-rays) alone can only provide a partial evaluation of the periodontal condition: a complete evaluation of periodontal condition can only be performed by the use of a periodontal probe. This procedure enables the doctor to measure the depth of periodontal pockets in up to six locations per tooth thus establishing a baseline index by which any future probing measurements can be compared. Early diagnosis of periodontal disease can, in most cases, assist in proper treatment protocols and, with proper home care and periodic professional periodontal care in periodontal probing examination.

In order to complete this examination, a needle-like metal or plastic probe demarcated in 1-millimeter increments is inserted between the tooth and gum tissue in six locations around each natural tooth (3 locations on the cheek side and 3 locations on the tongue/plate side). You may experience some sensitivity and/or bleeding during or after this examination. No local anesthetic is utilized in performing this examination.

PLEASE CHECK ( ) ONLY ONE BOX.

- I would like to have a complete periodontal probing examination.
- I would like to have my regular dental examination and decline to have the periodontal probing examination. I understand that I am releasing Dr. Grillo from any liability from not having a periodontal probing examination.

I have read the above passage and know and understand the contents thereof as to the necessity of the periodontal probing examination in determining, detecting and diagnosing disorders of the periodontal support structures. I understand by declining periodontal probing I hereby remise, release, acquit, satisfy and discharge the said release (Dr. Grillo and associates) of and from all action or actions, cause and causes of action, suits, debts, damages, judgments, claims and demands whatsoever, which said releaser ever had, now has, hereafter can, shall or may have against said release. I sign this release voluntarily with knowledge of its significance intending to be legally bound thereby.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_



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## CONSENT OF TREATMENT

1. **EXAMINATION AND X-RAYS:** I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.
2. **CHANGES IN TREATMENT PLAN:** I understand that, during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination- the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions to the treatment plan as necessary.
3. **DRUGS, MEDICATION, AND SEDATION:** I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand this and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of any anesthetic medication or drugs that may be given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.
4. **FILLINGS:** I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.
5. **CROWNS, BRIDGES, VENEERS AND BONDING:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.
6. **DENTURES- COMPLETE OR PARTIAL:** I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not in the initial denture fee.
7. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save a tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
8. **PERIODONTAL TREATMENT:** I understand that serious periodontal conditions causing gum inflammation and/or bone loss can lead to the loss of my teeth. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.
9. **REMOVAL OF TEETH (EXTRACTION):** I understand that if a tooth is not savable by e.g. root canal therapy, crowns, periodontal surgery, etc., it may be recommended that the tooth be extracted. I understand removing teeth does not always remove all infection if present and it may be spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia)
10. that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
11. **TEMPORAMANDIBULAR JOINT DYSFUNCTIONS (TMJ):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

**CONSENT:** I have read and understood the above information. Further, I understand that dentistry is not an exact science: therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_