RICHARD J. GARCIA, DMD

We are pleased to welcome you to our practice. Please complete the following information.
We look forward to working with you in maintaining your dental health.

PATIENT REGISTRATION AND HEALTH HISTORY FORM		
Today's Date:	**Date of Birth:**	**Marital Status:** M S Other:
Last Name:	**First Name:**	**Middle Initial:**
Primary Street Address (Local Florida Address):		
City:	State:	Zip Code:
Are you a seasonal resident? YES NO	**If seasonal, please list which months in Naples**:	
Home Phone #: ( )	Cell Phone #: ( )	
E-mail:	Work Phone #: ( )	
Place of Employment:	Occupation:	

How did you hear about our practice?

- Yellow Pages
- Church Bulletin
- Website/Internet
- Friend/Patient Referral: If so, please provide name:_______________________________
- Location
- Other: _________________________________

What is the reason for your visit today?

Emergency Contact Name:	Relationship:	Phone#:

MEDICAL HISTORY

Are you allergic to any of the following? (Please circle)

Anesthetic	Latex
Codeine	Sulfa
Erythromycin	Iodine
Penicillin	Other:______________________________

Please list any medications you are taking:____

____

____

Local pharmacy name /location: Pharmacy Phone #: ( )

Are you required to **pre-medicate** prior to dental procedures?: (*Please circle*)	YES	NO
Within the past year has there been any changes in your general health?	YES	NO
What was the approximate date of your last physical exam?		
Do you take any **blood thinner** medication?:	YES	NO

Are you a smoker?	YES	NO

MEDICAL CONDITIONS

Please indicate any conditions that you have:

- AIDS
- Anemia
- Artificial Heart Valve(s)
- Artificial Joint(s) Date:________
- Asthma
- Bleeding with extractions or surgery
- Cancer
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Cough
- Diabetes
- Emphysema
- Epilepsy
- Fainting
- Glaucoma
- Headaches
- Heart Murmur
- Heart Problems
- Hemophilia
- Hepatitis____Type
- Herpes
- High Blood Pressure
- HIV Positive
- Jaw Pain/TMJ
- Kidney Disease
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Nervous Problems
- Organ Transplant
- Pacemaker
- Radiation Treatment
- Rheumatic Fever
- Shortness of Breath
- Sinus Trouble
- Stroke
- Swollen Neck Glands
- Thyroid Problems
- Tuberculosis
- Tumors or growth on head or neck
- Ulcer
- Venereal Disease
- Other:___________________ ________________________

WOMEN ONLY : Pregnant? YES NO	If Pregnant, please provide Due Date:__________________	Taking Birth Control Pills? YES NO (Taking antibiotics may reduce effectiveness)

List all surgeries & dates:____

Name of your primary physician:	Phone # ( )
Name of your previous dentist:	Phone # ( )
Seasonal Patients: Name of your northern dentist:	Phone # ( )

SMILE EVALUATION

Please answer the following YES or NO questions:		
Are you pleased with the color of your teeth?	Y	N
Are you pleased with the shape of your teeth?	Y	N
Are there any old fillings or work that you are not pleased with?	Y	N
Do your gums bleed when you brush or floss?	Y	N
Do you grind your teeth (either consciously or in your sleep?)	Y	N
Are any of your teeth loose, or are you concerned about teeth loosening?	Y	N
Any other comments you wish to share about your teeth?		

I hereby certify that I have read and understood the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

_______________________________________ _________________________

Patient Signature (or Parent/Guardian) Date

_______________________________________ _________________________

Dr. Signature Date

TO BE COMPLETED AT PATIENT'S NEXT YEARLY EXAMINATION

- There have been no changes to my Medical/Dental History
- There have been changes to my Medical/Dental History (See new completed form)

_____________________________________ _________________________

Patient Signature Date

RICHARD J. GARCIA, DMD

PRACTICE'S POLICY

Our mission is to deliver the finest dental care available today. Fine dentistry is truly an investment; our goal is to help make that investment possible. We are a fee per service practice, payment is due at the time dental services are rendered. Patients with dental insurance will be provided with a completed claim form at checkout to submit to their insurance company for reimbursement based on their insurance benefits. Our practice is not an insurance provider. Please remember insurance is a contract benefit between patient and the insurance company. Patient is responsible for payment of all dental services provided. If you have dental insurance, please bring your insurance card up front to the reception counter along with your completed patient registration and health history form.

The following payment options are available for your convenience; Check, Cash, Credit Cards (Visa, MasterCard or Discover.) If paying by cash or by check for treatment over $1,000 please ask about our pre-payment discount.

Flexible Monthly Payment Plans are available through Care Credit. Applications for Care Credit are available in our office or you may apply online at carecredit.com

Any treatment that may be diagnosed and presented will only be valid for a period of 3 months from the date of the patient diagnosis; this is due to the fact that if left untreated, condition may worsen and may require more extensive treatment.

APPOINTMENTS

We understand that an unforeseen emergency may arise at any time. Please be advised that in the event you have to re-schedule an appointment we ask for the courtesy of at least 24 to 48 hour advance notice, so that we may offer the time to another patient. We also reserve the right to charge a missed appointment charge of $50.00 if our office was not given advance notice, or for no shows. We thank you in advance for your understanding in respecting the practice's time. As a courtesy we mail a reminder post card for all of our hygiene appointments, as well as we will call and/or email 1 to 2 days prior to appointment to remind you of your appointment. We respectfully ask that you please confirm your appointments.

ACKNOWLEDGEMENT

I hereby certify that I have read and understood the practice policies and have been given a copy of this Policy.

____
Patient Name (Please Print)

____ ________________________
Patient Signature (or Parent/Guardian) Date