Derek R. Morris, D.D.S.
Norman Archambo, D.M.D.
500 Highway 19 South • Palatka, FL 32177 • 386-325-5467

PATIENT INFORMATION

Name _____ Preferred Name _____ Date _____

Mailing Address _____

City _____ State _____ Zip _____

Home _____ Work _____ Cell _____ Best # to call ☐H ☐W ☐C

Social Security Number _____ D.O.B. _____ Age _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Minor Email Address _____

Employer _____ Occupation _____

Has any member of your IMMEDIATE family been treated in our office? ☐ YES ☐ NO

Whom may we thank for referring you to our office? _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Relationship to Patient _____

Emergency Telephone Numbers Home _____ Cell _____ Work _____

FAMILY INFORMATION

SPOUSE / PARENT / GUARDIAN INFORMATION

Name _____

Mailing Address _____

Telephone #'s HM _____ CELL _____ WK _____ Birth Date _____ SS# _____

Employer _____

PERSON RESPONSIBLE FOR ACCOUNT

Please check one ☐ Patient ☐ Spouse ☐ Father ☐ Mother ☐ Guardian

INSURANCE INFORMATION

Name of PRIMARY Insurance _____ Insurance Phone # _____

Insurance Address _____

Policy Holder _____ Policy Holder's D.O.B. _____ S.S. # _____

Name of Employer _____ Group # _____ Effective Date _____

We will bill your insurance, and if necessary, re-bill when an error has been made. However, it is not our responsibility to make sure that your insurance company makes payment. It is the responsibility of the insured. We will give your insurance company 60 days to make payment. We will make every effort possible to assist you in making your claim. If you are disputing a non-payment, this is between you and your insurance carrier. We cannot carry a balance while you are disputing the pending claim.

Signature _____ Date _____

Parental consent to display photo on picture board X _____

Failure to give 24 hours notice will incur a $30 charge for missed appointment

OVER

MEDICAL HISTORY

	YES	NO
Are you currently under a physician's care for an ongoing condition? If so, what? _____	☐	☐
Have you had any operations?	☐	☐
If so, what? _____		
Have you been hospitalized in the past 2 years?	☐	☐
Are you pregnant? Months? _____	☐	☐
Are you taking birth control pill?	☐	☐
Are you currently taking any medications?	☐	☐
If so, what? _____		
Are you allergic to any medications	☐	☐
and/or any anesthetics?	☐	☐
If so, what? _____		
Are you allergic to latex?	☐	☐
Are you allergic to any foods or materials?	☐	☐
If so, what? _____		
Do you smoke or chew tobacco?	☐	☐

Previous Dentist _____

Phone # _____

Reason for your Visit today _____

DENTAL HEALTH

	YES	NO
Are you having a dental problem?	☐	☐
Previous gum disease/or treatment?	☐	☐
Do you clench or grind your teeth?	☐	☐
Are you happy with the appearance of your teeth?	☐	☐

Have you ever had any of the following?	YES	NO
Heart disease/Stroke	☐	☐
Rheumatic Fever	☐	☐
Premedication	☐	☐
Mitral valve prolapse/Heart Murmur	☐	☐
High/Low blood pressure	☐	☐
Blood disease or disorder	☐	☐
Ulcer or Colitis	☐	☐
Head Injury	☐	☐
Lung disease/Tuberculosis	☐	☐
Asthma or Allergies	☐	☐
Hepatitis/Liver disorders	☐	☐
Kidney Disorders/Diabetes	☐	☐
Venereal disease	☐	☐
AIDS or HIV positive	☐	☐
Chemo/Radiation therapy	☐	☐
Artificial joints	☐	☐
Thyroid	☐	☐

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE RESPONSIBLE PARTY SIGNATURE CHANGES

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my teeth, or if my medications change, I will inform you at the next appointment without fail.

CONSENT FOR DENTAL TREATMENT

I request and consent to all dental procedures which my dental conditions or those of my dependents may require, and understand that procedures in dental surgery diagnosis and treatment are not an exact science and no guarantees as to the outcome of my treatments will be offered-only that they will exercise his professional expertise and ability in my best interest according to their best judgement. In consenting to any oral surgery, I understand that possible hazards may include, but are not limited to: pain, bleeding, swelling, bruising, infection; tingling or numbness of the lips, tongue, gums and/or face; loss or damage to other teeth or restoration; root or tooth into the sinus; oral antral fistula, maxillary sinusitis; possible mandibular fracture; and postoperative hemorrhage and discomfort. Adverse reactions to materials, medicines, anesthetics and procedures are possible in dentistry possibly resulting in, but not limited to, pupil irritation, root canal treatment, loss of teeth, necrosis, infection, pain, anaphylactic shock, and intestinal or systemic upset and I voluntarily assume all possible risks. I consent to the fees charged for services provided and they are satisfactory to me. I accept my dentist and understand he will exercise all his professional knowledge to the best of his ability.

		X
DATE	NAME OF PATIENT (PLEASE PRINT)	SIGNATURE OF RESPONSIBLE PARTY

Initials _____ I have read and been given the opportunity to receive a copy of the Notice of Privacy Policies