Perfect Smile Dental Studio
24632 State Road 54
Lutz, FL 33559

(813)948-6335

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

What is the best way to communicate with you?

☐ E-mail ☐ Home phone ☐ Mobile phone ☐ Work phone ☐ Text message

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Internet
☐ Newspaper ☐ School ☐ Work
☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

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Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ ____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ ____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ ____ _____

City State Zip Code

Response Date: _____

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Consent For Treatment

I hereby authorize doctor or designated staff to take x-rays, study models and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics,sedatives and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.

I give consent to the doctor or designated staff's use and disclosure of any oral , written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due in advance, (pre-paid), unless other arrangements have been made.

Print Patient Name

☐ By checking this box, I acknowledge that I have read this statement and agree to the content.

Relationship to Patient

◯ Self ◯ Parent/Guardian

Response Date:

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HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and Disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to Dr Ana Maria Bush.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Print Patient Name

Relationship to Patient

☐ Self ☐ Parent/Guardian

☐ By checking this box, I acknowledge that I have read this statement and agree to the content.

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Photo Authorization

I do hereby authorize Perfect Smile Dental Studio to take photographs, slides, and/or video of my face, jaw, and the hard/soft tissue of my mouth.

I understand that these photographs, slides, and /or videos will be a part of my permanent dental records.

I also understand that these photographs, slides, and /or videos, may be used for educational, and professional purposes only. (may be displayed on our office website)

Please indicate the selection that applies to you:

- ☐ I do not consent to any pictures, slides, and/or videos.
- ☐ I consent to the use of my pictures, slides, and/or videos for office use only.
- ☐ I consent to the use of my pictures, slides, and/or videos for office use only as well as to be posted on the office website as mouth shots only(will not show my face), for before and after purposes

☐ By checking this box, I acknowledge that I have read this statement and agree to the content.

Relationship to patient:

☐ Self ☐ Parent/Guardian

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Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ _____ _____

City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ _____ _____ _____

Last First MI Preferred Name

Title: _____ Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Mr/Ms/Mrs/etc

Birth Date: _____ Email Address: _____

Phone: _____ _____ _____ _____ Best time to call: _____

Home Work Ext Mobile

Address: _____ _____

_____ _____ _____

City State Zip Code

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Medical History

Have you been under the care of a Physician during the past two years?

◯ Yes ◯ No

If yes, for what? Please indicate Physicians name and contact phone number.

Have you taken any drugs or medications within the past two years, or currently taking any drugs or medications?

◯ Yes ◯ No

If yes, please indicate medications and dosage, and directions of use.

Have you ever taken any prescription drugs for weight loss?

◯ Yes ◯ No

Do you have any allergies? (seasonal, antibiotics, latex, any other medications)

◯ Yes ◯ No

If yes, please indicate drug and reaction.

Women: Are you pregnant or think you may be pregnant?

◯ Yes ◯ No

Have you been hospitalized within the past five years?

◯ Yes ◯ No

If yes, please indicate reason and how long.

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If you suffer from any of the following, please indicate:

- [ ] Allergies
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Codeine Allergy
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Growths
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Latex Allergy
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] NO EPI
- [ ] Other
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] Pre Med
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

- [ ] By checking this box, I acknowledge that I have read this statement and agree to the content.

Relationship to patient

- [ ] Self
- [ ] Parent/Guardian

Response Date: _____