I ♥ My Dentist®

HEALTH QUESTIONNAIRE

PATIENT'S NAME: ______________________ **GUARDIAN:** ______________________

ADDRESS: ______________________ **CITY:** ______________ **STATE:** ______

ZIP: __________ **HOME PHONE:** ______________________ **CELL PHONE:** ______________________

EMAIL: ______________________ **DOB:** ______________________

DRIVER'S LIC.#: ______________________ **SS#:** ______________________

EMERGENCY CONTACT ______________________ **PHONE:** ______________________

PLEASE ANSWER EACH QUESTION (CIRCLE YES OR NO):

YES NO Have you been under the care of a physician during the past two years?
For what purpose? ______________________
Physician's Name: ______________________

YES NO Have you taken **any kind of medicine or drugs** during the past two years?
Please list: ______________________

YES NO Are you allergic to Penicillin?

YES NO Are you allergic to any other drug or medicine?
Please list: ______________________

YES NO Have you ever had any excessive bleeding requiring special treatment during an operation or dental extracton?

YES NO Have you been required to take pre-medication prior to dental treatment? For what purpose?
____

YES NO Have you ever taken a bisphosphonate drug (like Fosamax or Boniva) or any drug for osteoporosis or bone cancer? ______________________

YES NO Do you currently or have you ever used tobacco? ______________________

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

Heart trouble/attack	Hepatitis	Sinus Trouble	Radiation to Head or Neck
Congenital heart defect	Diabetes	Cancer	Organ Transplant
Heart Murmur	Tuberculosis	Anemia	Prosthetic Heart Valve/Heart
High Blood Pressure	Herpes	HIV/AIDS	Valve Replacement
Low Blood Pressure	Arthritis	Osteoporosis	Stroke
Asthma or COPD	Epilepsy / Seizures	Prosthetic Joints Knee or Hip	Other: __________

If you have any of these, please explain: ______________________
____

YES NO *(Women)* Are you pregnant or breastfeeding?

YES NO When was your last dental examination and cleaning? ______________________
Purpose of today's appointment/dental complaint: ______________________

YES NO Are you interested in cosmetic dentistry? YES NO Are you interested in Invisalign?

How did you learn of I ♥ My Dentist:
❑ Friend or Relative: __________ ❑ Internet: __________ ❑ Other: __________

CONSENT

I hereby authorize Dr. Johann Ramkissoon, DMD. and/ or legally qualified auxilliaries/associates to administer any treatment and anesthetics, as may be deemed necessary or advisable in the diagnosis and treatment of me (or my children, if I as a parent, have left him/her in the dentist's care). I understand I will be consulted before treatment is rendered. I understand the need for these questions to be answered truthfully. All questions have been answered truthfully, and in my own hand.

Signature ______________________ **Date** ______________
(PATIENT OR MINOR'S PARENT OR GUARDIAN)

Patient financial responsibility:

Name of responsible party *(if other than self)*:____

Relationship to Patient: ____

Work phone number:________________________ Home number if different than patient: __________________

In order to better serve our patients please specify how you will pay so that appropriate arrangements/paperwork can be made.
Please recognize that we can only estimate your co-payment, we do not receive any guarantees from the insurance company of how much they will pay until they have reviewed the claim.

Please check one of the following options:

______ Self Pay (Cash or Check)
______ Credit Card
______ Insurance Coverage with applicable co-payment and/or deductible payment.
***Please give your insurance card to the Front Desk so that we may obtain a copy for our records.**

Please read and ask the front desk any questions.

I certify that I have read and understand the above information to the best of my knowledge. The questions on the front and back have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize I Love My Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent to my insurance company, other health practitioners, or any authorized party listed above, this may be done electronically via secure internet connections. I authorize my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for my services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I understand payment is due at the time of service and in case by default I may be responsible for reasonable attorney's fees and all costs of collections. Payment default will also be processed/prosecuted in accordance with Florida law through the State's Attorney's Office.
I, the patient have been informed of my financial responsibility and will comply with this policy and I have read and fully understand the Privacy Act Notices of Dr. Johann Ramkissoon, DMD and agree and consent to this policy. ***(See clipboard)***

Missed Appointments

When you confirm an appointment with us, we reserve a time in our schedule exclusively for you. If you are unable to keep the appointment, we require **24 hours advance notice** to allow us sufficient time to schedule another patient in your time slot. Missed appointments, without the required advance notification or repeated cancellations, will result in the assessment of a **$75.00 broken appointment charge** for the unappointed time in our schedule.

X ____ **Date** __________________________

Signature of patient or guardian