Friedland
FAMILY DENTISTRY

WELCOME TO THE OFFICE OF DR. BRYAN FRIEDLAND

(Patient's) Name : _____ DATE _____

Date of Birth: _____ Male/Female - SS # _____

Address: _____ Apt # _____

_____

Phone numbers: H _____ C _____ W _____

Email Address: _____

Marital Status: S____ M____ Divorced/Separated ____ Widowed ____ Partnered ____

Employer: _____

Do you have dental insurance? Y_____ N_____ Name of Ins Company: _____

Are you the subscriber of insurance? Y_____ N_____

If yes, please present insurance information to the receptionist...

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

Emergency Contact: Name_____ Phone _____

Release

- I authorize the dentist and staff to perform diagnostic procedure and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning patient's health care advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning patient's health care advise and treatment provided to another dentist at my request
- I hereby authorize payment of insurance benefits directly to the dentist or PA, otherwise payable to me.
- I understand that my dental insurance benefits may pay less than what is anticipated or predicted by this dental office. I understand that I am responsible for payments in full of all accounts payable. I revoke all previous agreements to the contrary, and agree to be responsible for all payments of services not paid, in whole or in part, by my dental care payor, for any reason.

I attest to the accuracy of the information on this page.

Patient's Signature (or Guardian)_____ Date _____

Signature of Dentist _____

MEDICAL HISTORY

(Patient's) First Name _____ Last Name _____ Date of Birth_____

Are you under the care of a Physician?..... .....Yes No

Are you taking any medications? .....Yes No

If Yes, Please List: _____

_____

Are you allergic to any medications? .....Yes No

If Yes, Please List: _____

Are you allergic to anything else? .....Yes No

If Yes, Please List: _____

Are you pregnant or suspect you may be? ....Yes No

Do you have any heart conditions, valve issues, or a pacemaker? .....Yes No

Do you have high blood pressure or low blood pressure? .....Yes No If Yes, circle one HIGH LO'

Have you had chemo or radiation therapy? .....Yes No

Do you have any artificial joints or prostheses? .....Yes No

Do you have any blood disorders or bleeding problems? .....Yes No

Do you have any problems with any of the organs in your body?.....Yes No If Yes, Which? _____

Are you HIV positive or do you have AIDS? .....Yes No

Are you TB positive or do you have TB? .....Yes No

Do you have Hepatitis? .....Yes No If Yes, Which? _____

Are you diabetic? .....Yes No If Yes, Type? _____

Do you smoke, chew, or use other form of tobacco? .....Yes No Packs Per Day? _____

Do you have asthma, or other respiratory illnesses? .....Yes No

Do you use illicit drugs or habitually use controlled substances? .....Yes No

Are you under psychiatric care? .....Yes No

Do you have any seizure disorders? .....Yes No

Do you have a venereal disease? .....Yes No

Do you have an inflammatory disease or autoimmune disorders?.....Yes No

If you have any medical conditions not covered on this form, LIST THEM: _____

_____

I certify that the above information is complete and accurate

Patient's Siganture _____ **Date** _____

Dentist's Siganture _____ **Date** _____

DENTAL HISTORY

(Patient's) First Name _____ Last Name _____ Date of Birth_____

What is the purpose of your visit today? _____

When were you last at the dentist? _____

When was the last time your teeth were cleaned? _____

When were your last dental X-Rays taken? _____

Do you make regular visits to the Dentist? .....Yes No If Yes, how often? _____

Have you lost any teeth before? .....Yes No If Yes, were they replaced? YES

Would you like to know about permanent replacements for missing teeth? ...Yes No

Have you had problems with previous dental treatment? .....Yes No

Do you clench or grind your teeth during the day or overnight? .....Yes No Don't Know

Does your jaw click or pop? .....Yes No

Do you have facial pain or jaw muscle pain? .....Yes No

Are you sensitive to any of the following? (circle them) HOT COLD SWEETS PRESSURE CHEWI

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do your gums ever bleed? .....Yes No If Yes, When? _____

Do you have any chipped teeth? .....Yes No

Do you have any loose teeth.....Yes No

Are you unhappy with the appearance of your teeth? ..... Yes No

Are you unhappy with the way your breath smells? .....Yes No

Have you ever had "deep cleanings" or gum surgery? .....Yes No

Have you had braces in the past? .....Yes No

Do you have anxiety related to dentistry in any way, shape or form? ..... Yes No

If yes, please elaborate so we can better care for you. _____

_____

_____

I certify that the above information is complete and accurate

Patient's Siganture _____ **Date** _____

Dentist's Siganture _____ **Date** _____

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NO SHOW POLICY

We understand that there are legitimate reasons for having to miss an appointment. We ask you please show consideration by calling well in advance if you need to cancel or are unable to arrive on time for your scheduled appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor or hygienist.

Please let this notice serve to notify you, that if you fail to give a 24 hour notice of cancellation, based upon your appointment length, there will be a **MINIMUM** of **$50.00 broken appointment** fee that will be billed to your account and cannot be filed to your insurance.

_____ _____

Patient Signature Date

_____

Printed Name

10031 Pines Blvd. Suite W101 Pembroke Pines, FL 23024 (954)450-6640
BestPembrokePinesDentist.com

HIPAA Consent Form

For purposes of treatment, payment and healthcare operations

I, _____, consent to the use of disclosure of my protected health information by *Friedland Family Dentistry,* for purpose of diagnosis or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of *Friedland Family Dentistry*. I understand that diagnosis of treatment of me by *Friedland Family Dentistry* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclose to carry out treatment, payment or healthcare operations of the practice. *Friedland Family Dentistry* is not required to agree to the restrictions that I request, the restriction is the binding on *Friedland Family Dentistry* and the healthcare provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that the healthcare provider or *Friedland Family Dentistry* has taken action in reliance on this consent.

My "protected health information", including my demographic information, collected from me and created or received by my healthcare provider, another healthcare provider, a health plan, my employer or healthcare clearing house. This protected health information relates to my past, present and future physical or mental health or condition and identifies me or is reasonable basis to believe the information may indentify me.

I understand I have a right to request to review *Friedland Family Dentistry's* Notice of Privacy Practices prior to signing this document.

Friedland Family Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling and requesting a revised copy be sent in the mail or by asking for one at my next appointment.

_____ _____

Patient's Signature Date