Roberto R. Maal, D.D.S., P.A.
35 Newport Street
Cantonment, FL 32533
850-478-9930

Welcome to our Office

Patient's Name: ______________________________

Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated ☐

Date of Birth: ______________ SS#: ________________ Email Address: ________________

Home Phone: _____________ Cell Phone: ________________ Work Phone: ________________

Home Address: ______________________________

City: ____________________ State: _______ Zip: ________

Whom may we thank for referring you to our practice? ______________________________

Name, Location and Phone number of Preferred Pharmacy: ______________________________

In an emergency who should be notified? Please provide Name, Phone number and Relationship to patient below:

____

Employment Information

The following is for the: ☐ the patient's spouse ☐ the person responsible for payment

Employer Name: ______________________________ Phone: ________________

Employer Address: ______________________________

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient.

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

Patient's Name: ______________________________

Date of Birth: ______________ SS#: ________________ Email Address: ________________

Home Phone: _____________ Cell Phone: ________________ Work Phone: ________________

Home Address: ______________________________

City: ____________________ State: _______ Zip: ________

Primary Dental Insurance:

Name of Insured: ____________________________

Insured's Date of Birth: ______________ ID#: ________________ Group #________________

Insured's address: ______________________________

Insured's Employer Name: ______________________________

Employer Address: ______________________________

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

Insurance Plan Name: ______________________________

Insurance Address: ______________________________

____

Insurance Company Phone Number: ______________________________

Insurance Authorization:

☐ By checking this box,

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

What is your immediate concern? ______________________________

Previous Dentist Name and Phone Number: ______________________________

Date of most recent dental exam and dental x-rays: ______________________________

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Is there anything about the appearance of your smile that you would like to change? __________

Check all that apply:

☐ Had complications from past dental treatment ☐ Had trouble getting numb ☐ Had any reactions to local anesthetic ☐ You experience dry mouth ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth ☐ Food gets trapped between any teeth ☐ Have you ever whitened or bleached your teeth? ☐ Have you experienced popping and/or clicking of your jaw joint? ☐ You have difficulty chewing ☐ You clench or grind your teeth	☐ You wear or have worn a bite appliance ☐ Gums bleed when brushing or flossing ☐ Treated for gum disease or were told you have lost bone around your teeth ☐Noticed an unpleasant taste or odor in your mouth ☐ Experienced gum recession ☐ Had any teeth become loose on their own (without injury) ☐ Experienced a burning sensation in our mouth ☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe below:

I affirm that all information provided is true and accurate:

Patient Signature: ______________________________ Date: ______________

Dr. Roberto R. Maal, D.D.S., P.A.
35 Newport Street
Cantonment, FL 32533
850-478-9930

MEDICAL HISTORY

Patient Name: ______________________ ______________________ ____ ________________
Last **First** **MI** **Preferred Name**

Indicate which of the following conditions you have or have had. By checking the box, it will indicate a "YES" response leaving blank will indicate a "NO" response.

☐ *Pre-Med – Amox	☐ *Pre-Med – Clindamycin	☐*Pre-Med – Other	☐ Allergies
☐ Allergy – Aspirin	☐ Allery – Codeine	☐ Allergy – Erythromycin	☐ Allergy – Hay Fever
☐ Allergy – Latex	☐ Allergy – Other	☐ Allergy – Penicillin	☐ Allergy – Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Diabetes	☐ Dizziness/Fainting
☐ Epilepsy	☐ Excessive Bleeding	☐ Frequent Headaches	☐ Glaucoma
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ HIV/AIDS	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Mental Disorders	☐ Nervous Disorders	☐ Osteoporosis
☐ Pacemaker	☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐Rheumatism	☐ Sinus Problems	☐ Stomach Problems
☐ Stroke	☐ Tobacco/Alcohol Use	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Venereal Disease	☐ X-Other	

*Do you take antibiotic premedication for your dental visits? ☐ Yes ☐ No If yes, please explain below:

____

☐ Ever been hospitalized (illness or injury) ☐ Presently being treated for any other illnesses
☐ Current or past use of Osteoporosis medications
☐ FEMALE: Taking birth control pills ☐ FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your Physician and phone number? ______________________________________

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. ______________________________________

Are you currently taking any medications (prescription and non-prescription) including regular doses of pain or aspirin? If yes, please list all medications and dosages below:

____

____

☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

____

PATIENT SIGNATURE DATE

Roberto R. Maal, D.D.S., P.A.
35 Newport Street
Cantonment, FL 32533
850-478-9930

Patient Name: ______________________

Consent for Services and Financial Policy

As a condition of treatment by this office financial responsibility on the part of each patient must be determined before treatment.

Insurance claims are filed as a courtesy. I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to pay within 90 days, I will be responsible for the full amount. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time of condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

We reserve the right to charge for appointments broken without 72 hours' notice. The broken appointment charge normally ranges from $75.00 to full fee of appointment scheduled. Your consideration is greatly appreciated. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ **By initialing this box, I understand the above information and agree with its contents.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.
I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and if so, may not be subject to federal or state law protecting its confidentiality.

By signing below, I agree that I have completely read and understand the foregoing agreement.

______________________________ Date: ______________________

Photo Release: We often take pictures at our office to be used for, but not limited to social media, printed material and for educational purposes. By checking the appropriate box, you are giving Roberto Maal, D.D.S., PA consent to use photos of you or your child in this manner. You also understand there is no payment for such use of photos.

☐ **Yes, you can take and use photos** ☐ **No, I don't want pictures taken.**