

# Patient Registration

Please fill out these forms completely. The better we communicate, the better we can care for you!

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Middle initial \_\_\_\_\_  
Preferred name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
Responsible party(if someone other than patient): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact information Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_ e-mail: \_\_\_\_\_  
How do you prefer to be contacted? \_\_\_\_\_ when? \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
Sex:  Male  Female Marital Status:  Single  Married  Separated  Divorced  Widowed  
Employment status:  Fulltime  Part-time  Retired Student Status:  Fulltime  Part-time

## Authorization to Release Medical/Dental Information

I authorize the following person(s) to have access to my protected health information. I have listed their name and relation to me.

Name: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

I understand that I have the right to restrict the amount or type of information that the above individual(s) receive. Following are restrictions I would like to place:

May we leave a message on your HOME answering machine if there is no answer?  Yes  No

If there are any changes to the above stated information, it is the patient/guardian's responsibility to inform G.D.A. in writing.

I hereby acknowledge that I have been presented with a copy of the currently effective Gator Dental Associates, PA Notice of Privacy Practices & authorize the above listed person(s) access to my protected health information. A copy of this signed, dated acknowledge shall be as effective as the original.

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name (print): \_\_\_\_\_ Witness: \_\_\_\_\_

## Informed Consent

I hereby authorize and request the performance of dental services for myself, or for \_\_\_\_\_, who I am responsible for.

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment.

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items to me, to my minor/child, or to the patient whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_



**MEDICAL HISTORY**  
FOR

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

- Women: Are you
- Pregnant/Trying to get pregnant?  Nursing?
  - Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics
- Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism            | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# Gator Dental Associates, P.A.

6605 SE 221<sup>st</sup> Street  
Hawthorne FL 32640

www.gatordental.com

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Jay H. Garlitz, DMD

Simon T. Amir, DMD

## CONSENT FORM TO OBTAIN DENTAL RECORDS

I hereby consent to the release of a copy of dental radiographs for:

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(Patient's Name)

From the office of: ----- at  
(Dentist's Name)

----- to the office of  
(Dentist's Address)

**Gator Dental Associates, P.A.**

Thank you,

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(Patient's Name - please print)

-----  
(Patient's signature or legal guardian)

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(Date)