595 Bay Isles Road, Suite 110 | Longboat Key, Florida 34228
(941) 383-6400 | Fax (941) 383-6435
www.longboatkeydental.com | LBKDental@hotmail.com

Confidential Patient Information

Name: Dr. / Mr. / Mrs. / Ms. _____ ❑ M ❑ F Date: _____
(Please circle) (Last) (First) (MI) (Nickname)

Primary Address: _____
(Street) (Unit / Apt / Suite) (City / State) (Zip)

Are you a transient resident? _____ Are you on vacation? _____
(Dates) (Dates)

Secondary Address: _____
(Street) (Unit / Apt / Suite) (City / State) (Zip)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Birthdate: _____ Age: _____ SSN: _____

Marital Status: _____ Employer: _____

Hobbies / Interests: _____

Family Members (Children, Grandchildren): _____

Have you been a patient in this office before? ❑ Yes ❑ No If yes, when? _____

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

How did you hear about us? _____

Emergency Contact – Name: _____ **Phone:** _____ **Relationship:** _____

Medical Doctor: _____ Phone: _____

Cardiologist: _____ Phone: _____

Physical Therapist: _____ Phone: _____

Pharmacy Name: _____ Location: _____ Phone: _____

Financially Responsible Party

Please check one: ❑ **Self** ❑ **Parent** ❑ **Guardian** ❑ **Benefactor** ❑ **Power of Attorney** (see Page 4 regarding Financial & Insurance Policy)

Name: Dr. / Mr. / Mrs. / Ms. _____ ❑ M ❑ F Marital Status: _____
(please circle) (Last) (First) (MI) (Nickname)

Address: _____
(Street) (City / State) (Zip)

Home Phone: _____ Cell Phone: _____ Birthdate: _____ SSN: _____

I understand that unless other arrangements have been made prior, all fees are due in full the day the service is rendered. I authorize the practice of Longboat Key Dental (LBKD) to disclose pertinent medical / dental information to my insurance company when indicated to facilitate a claim.

Signature of Patient (If a minor, signature of legal guardian): _____ Date: _____

Confidential Health Questionnaire

Please list all the medications you are taking, including: Over-the-Counter Drugs, Herbs and Supplements
If you have a RX list or USB medical file, may we copy it? ❑ Yes ❑ No

Medication	Dosage	Times/Day	Medication	Dosage	Times/Day

Have you ever taken bisphosphonate drugs (drugs that strengthen your bones)? ❑ Yes ❑ No _____

Are you allergic to any medications / materials? ❑ Yes ❑ No

Allergy List (please check):

❑ Aspirin	❑ Barbiturates (Sleeping Pills)	❑ Iodine
❑ Local Anesthesia	❑ Penicillin	❑ Sulfa
❑ Latex	❑ Nickel	❑ Other _____

Do you tolerate Codeine? ❑ Yes ❑ No

What is your general state of health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have or have you ever had (please check):

❑ Heart Attack	❑ Shortness of Breath	❑ Arthritis
❑ Heart Murmur	❑ COPD / Emphysema	❑ Osteoporosis
❑ Angina or Chest Pain	❑ Asthma	❑ Artificial Joints
❑ Artificial Heart Valve	❑ Sinus Problems	❑ Tuberculosis
❑ Heart Valve Problems	❑ Stroke / TIA	❑ Glaucoma
❑ Heart Surgery	❑ Epilepsy / Seizures	❑ Thyroid Disease
❑ Heart Stent	❑ Fainting / Dizziness	❑ Gastritis / Colitis / IBS
❑ Pacemaker / Defibrillator	❑ Neurologic Disease	❑ Autoimmune Disease
❑ Irregular Heart Beat	❑ HIV or AIDS	❑ Chronic Pain
❑ Atrial Fibrillation	❑ Hepatitis / Liver Disease	❑ Depression / Anxiety
❑ Congenital Heart Disease	❑ Diabetes	❑ Alcohol or Drug Abuse
❑ Ankle Swelling / Heart Failure	❑ Kidney Disease	❑ Anemia / Abnormal Bleeding
❑ High Blood Pressure	❑ Vascular Disease	❑ Malignancy / Cancer

❑ None

Do you have any condition, disease or problem not previously listed? _____

Do you use tobacco products in any form? ❑ Yes ❑ No Do you use any alcohol products? ❑ Yes ❑ No

Have you been hospitalized in the past 3 years? ❑ Yes ❑ No If so, why? _____

Are you in chemotherapy, radiation therapy, or other cancer treatments currently? _____ Schedule? _____

Have you ever had radiation therapy to the head or neck? ❑ Yes ❑ No Comment: _____

Has your physician seen you within the past 2 years? ❑ Yes ❑ No ❑ N/A Why?_____

Female Patients Only

Are you pregnant or nursing? ❑ Yes ❑ No Do you use oral contraceptives? ❑ Yes ❑ No
(If unsure, please check with your physician prior to any surgical procedure.)

Certain antibiotics prescribed in this office may interfere with the effectiveness of oral contraceptives. It is recommended that you use an additional method of birth control if antibiotics are prescribed. However, continue the use of your birth control as prescribed.

I have read, understood, and attest that the medical history I have given is full and correct. I understand it is my responsibility to inform LBKD if I, or my minor child, ever has a change in both health or insurance coverage.

Print Name:_____Date: _____

Patient Signature: _____

Authorization & Release (Relation to Patient) ❑ Self ❑ Mother ❑ Father ❑ Guardian

Dental History

Former Dentist: _____ Phone #: _____

Last Dental Visit Date: _____ Visit Frequency: _____ Last Dental X-Ray Date: _____

Have You Had (please check):

❑ Periodontal Surgery (Gum) ❑ Endodontic Treatment (Root Canal) ❑ Orthodontic Treatment (Braces)
❑ Oral/Implant Surgery (Bone) ❑ Prosthodontic Treatment (Denture) ❑ Don't Know

Names of other current dental professionals_____

Do you have recurrent problems w/ any of the following (please check)?

Bad Breath	❑ Yes	Jaw Joint Painful or Tender	❑ Yes
Bleeding / Swollen / Tender Gums	❑ Yes	Loose Teeth or Broken Fillings	❑ Yes
Blisters on Lip	❑ Yes	Muscle Pain	❑ Yes
Burning Sensation on Tongue	❑ Yes	Periodontal Disease	❑ Yes
Chew on One Side of Mouth	❑ Yes	Sensitivity to Hot and or Cold	❑ Yes
Clicking / Popping / Grating Jaw	❑ Yes	Sensitivity to Sweets	❑ Yes
Dry Mouth	❑ Yes	Sensitivity When Biting	❑ Yes
Fingernail Biting	❑ Yes	Sores or Growths in Mouth	❑ Yes
Food Collection Between Teeth	❑ Yes	Headaches / Migraines	❑ Yes
Grinding Teeth	❑ Yes	Sleep Apnea	❑ Yes

How often do you floss? _____ How often do you brush? _____

Any other dental problems not listed?_____

Getting to Know You

Dental Desires & Dental Knowledge

Please Indicate Dental Desires:

❑ Straighter Teeth / Invisalign ❑ Replace / Fix Teeth ❑ Healthy Gums ❑ Specific Problem
❑ Comprehensive Dental Examination ❑ Just Cleanings ❑ Smile Assessment ❑ Implant Therapy

In Your Opinion, What is Your Dental IQ:	Low (1)	(2)	(3)	(4)	(5) High
Past Experience of Previous Dental Work:	Poor (1)	(2)	(3)	(4)	(5) Great
Fear of Dental Work and/or Dentists:	Low (1)	(2)	(3)	(4)	(5) High
Motivation to Treat Your Dental Problems:	Low (1)	(2)	(3)	(4)	(5) High

Please Circle One:

When discussing my treatment plan I prefer:

The Big Picture **Detail by Detail**

When evaluating my smile, it's important:

What I See **What Others See**

The type of patient I would consider myself to be is:

ProActive **Reactive**

Office Notes: _____

_____

_____

_____

_____

_____

WE WELCOME ALL PATIENTS

Our goal is to help you take care of your teeth, smile and mouth at a level that is right for you.

We believe that it is your choice on the level of care that you want in our practice. We will help you thoroughly understand your dental choices so you can make the best decision possible. Your first choice is how you would like us to work with you. Before arriving for your appointment, please consider the following guidelines for your care so that we can best meet your goals:

□ LEVEL 1: URGENT CARE

Patients at this level choose treatment only when they experience a crisis such as pain, swelling or bleeding that requires immediate treatment. Urgent care patients are generally not focused on taking steps to ensure future urgencies do not occur. They come in when they know they have a major problem to deal with and the condition has developed to a point of urgency in order to control pain or save the tooth.

□ LEVEL 2: REMEDIAL CARE

Patients at this level choose treatment for obvious problems such as broken or cracked teeth, cavities, sensitivity, discomfort or concerns that are creating issues in the mouth right now. Remedial care patients are usually not focused on taking steps to prevent new concerns or improve their health over time. They only want to deal with concerns that have already developed into conditions that require treatment to remove existing disease or repair the teeth back to the most basic level of health.

□ LEVEL 3: PROACTIVE CARE

Patients at this level seek treatment for existing concerns just like remedial care patients, but they are also concerned about conditions that may create problems in the near future. These patients generally want to maintain the health of each tooth at a basic level so they also do what they can to prevent new concerns from developing. When treatment is recommended, proactive care patients usually prioritize their treatment to manage their costs but still take care of things soon enough so that known concerns are less likely to develop into major problems.

□ LEVEL 4: COMPLETE DENTISTRY

Complete dentistry patients are concerned about the current conditions in their mouth, the causes of dental disease and their long-term health. They want to know their full treatment options so they can become and remain as healthy as they can be, thereby minimizing their long-term dental costs. These patients often choose a step-by-step master plan focused on restoring their health combined with prevention and regular care to achieve steady long-term dental health and an improved appearance to their smile over time.

□ LEVEL 5: OPTIMAL DENTISTRY

Just like complete dentistry patients, patients at this level are focused on long-term dental health and disease prevention, but they also want their teeth and smile to look great. Patients at this level are interested in treatment options to correct all dental concerns for lifelong optimal function and appearance. For some of these patients, enhancing their appearance with a beautiful new smile is very important.

When you come in for your first appointment, we will review these levels of care with you to help you choose how we should start with you. It is not uncommon for people to begin at one level and progress to higher levels when they are ready. We're here to help you discover what is right for you so your teeth, smile and mouth remain as healthy as they can be for life based on your goals.

Dr. Michael O'Neil, DDS
595 Bay Isles Rd. Suite 110
Longboat Key, FL 34228
941-383-6400 ~ LBKdental@securedds.com

Patient Authorization for Disclosure of Information

DO WE HAVE YOUR PERMISSION TO?:

Leave the following information on your home answering machine or voice mail:

Appointment Related	YES	NO
Billing/Payment Information	YES	NO
Dental/Health Information	YES	NO
May we contact you at work?	YES	NO

Please list family members, friends or personal care givers that you give permission to receive the following information about you:

_____

_____

_____

Appointments: YES NO **Dental/Health Information:** YES NO **Billing:** YES NO

- I understand that if the person(s) or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be disclosed by the recipient and may no longer be protected by federal law.
- I understand I may revoke this authorization at any time by notifying the office of Dr. Michael O'Neil, DDS in writing.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date

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Office Policy

Insurance Information

Insurance Company: _____

Insurance Phone #: _____

Group #: _____

Subscriber's Name: _____

Date of Birth: _____

SSN: _____

We need your license / I.D. here, *please and thank you.*

At **Longboat Key Dental**, we strive to deliver the very best comprehensive oral health care available in today's ever-changing world. Our treatment exams, recommendations, and services are tailored to your individual needs. It is important for you, the patient, to recognize that treatment recommendations are not determined by insurance coverage. Please initial below indicating that you have understood, acknowledged, and received the following office policies:

Initial

_____(1) Your new patient exam will be comprehensive. There will be topics discussed that you may be familiar with or you may be hearing for the first time. We will make every attempt necessary to explain the nature of recommended treatments and the purpose for them. In order to do so, a consultation appointment will be scheduled after your initial exam visit to showcase your needs. We may take records that you may not be normally accustomed to. Such records may require a fee that will be disclosed to you in advance. By refusing such records, you must acknowledge that treatment could result in less than ideal outcomes.

_____(2) I have read, understand, and received a copy of Longboat Key Dental's **Financial & Insurance Policy (Circa 2015)**.

_____(3) I have read, understand, and received a copy of Longboat Key Dental's **Payment Options (Circa 2019)**.

_____(4) I have read, understand, and received a copy of Longboat Key Dental's **X-Ray and Records Policy (Circa 2015)**.

_____(5) Privacy Policy: We are providing you with our Notice of Privacy Practices. By initialing on this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare operation as stated in the policy, and as agreed on the Patient Authorization for Disclosure of Information. Your initials will also indicate acknowledgement of receipt of **Notice of Privacy Practices**.

I AGREE WITH THE ABOVE CONDITIONS.

Print Name: _____ Date: _____

Patient / Parent or Guarantor Signature: _____

Common Patient Concerns

Please circle the number next to the statements that concern you or describe your situation.

1. I have not been to the dentist for a long time, and I feel worried about what you will say about by teeth and my oral hygiene.
2. My teeth are very sensitive.
3. Pain relief is top priority for me.
4. I'm very anxious about injections.
5. I feel out of control in the dental chair (or I have an extreme problem with lying down).
6. I gag easily.
7. I hate noise of dental instruments.
8. Please tell me about the treatment options and the ways these can be carried out.
9. I need to know that you will stop when I give a pre-agreed "stop" signal during treatment.
10. It would help me if you could explain to me what you are doing and why.
11. I have health problems that we need to discuss.
12. There are other issues I'd like to talk about that aren't covered on this form.

Name:_____ Date:_____

Reason For Today's Visit

Patient Name: _____ Date: _____

Reason for Today's Visit (Chief concern in your own words):_____

_____

_____

_____

_____

_____

1. How do you feel about the appearance of your smile? _____

_____

2. If you could change anything about your smile, what would it be? _____

_____

3. What improvements would you like to make in your mouth?_____

_____

4. Please add anything that you feel is important: _____

_____

_____

_____

_____