family, cosmetic, and implant dentistry
andrew j. holloman, dds & associates

2127 NE Coachman Road
Clearwater, FL 33765
Call: (727) 581-1441
Fax: (727) 585-4766
www.ClearwaterFLDentistry.com

Welcome!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. Please fill out this form as completely as possible. We want to make sure that we are well-informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Today's Date: _____ How did you hear about us? _____

Name (First, Middle, Last): _____

I prefer to be addressed as: _____ Circle One: Male Female

Birthdate: _____ Age: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Circle One: Single Married Widowed Divorced Separated Partnered

Spouse's Name: _____

Spouse's Birthdate: _____ SS#: _____

Spouse's Employer: _____ Occupation: _____

When and where are the best times to reach you? _____

Other Family Members (and Ages) Seen by Us: _____

EMERGENCY CONTACT (Please specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

REFERRAL

Whom may we thank for referring you to our practice?

Name: _____ Relationship: _____

DENTAL INSURANCE

Person Responsible for Account (If other than yourself): _____

Do you have dental insurance coverage? Yes No

Dental Insurance Co. Name: _____

Dental Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance Co. Phone: _____

Group # (Plan, Local, or Policy#): _____

Insured's Name: _____ Relationship: _____

Insured's Birthdate: _____ SS#: _____

Insured's Home Phone: _____ Alt. Phone: _____

Insured's Employer: _____ Occupation: _____

We will file your dental insurance claim as a courtesy to you and accept assignment of benefits. All claims and billing statements are filed electronically for speedy reimbursement. We can only estimate your insurance coverage, as it is subject to approval by your insurance company. If you are concerned about coverage, we can file a "Preauthorization of Treatment" to confirm how much your insurance company will pay. Preauthorization is not done automatically; therefore, please request it if you are interested. Your dental insurance is a contract between you and your insurance company. We will assist you in dealing with your insurance company, but the ultimate responsibility is yours. Secondary insurance must be filed by the patient.

ACKNOWLEDGEMENTS & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status that will affect my care at this office.

Signature: _____

Date: _____

I understand that I will be required to pay my estimated portion of Andrew J. Holloman, DDS & Associate's fees for myself and/or my dependents at the time of treatment, unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement. See additional financial policies on Page 4.

Signature: _____

Date: _____

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MEDICAL HISTORY

Do you have a physician? Yes No Physician's Name: _____ Phone: _____

Date of Last Physical: _____ Current Physical Health: Excellent Good Fair Poor Very Poor

Are you currently under the care/supervision of a physician? Yes No Please Explain: _____

Are you currently taking any prescription or non-prescription medications? Yes No Please List Medications with Correlating Diagnosis: _____

Have you ever taken bisphosphonates? Yes No

For Women: Are you currently taking any oral contraceptives (birth control pills)? Yes No Are you pregnant? Yes No Are you nursing? Yes No

Do you or have you ever used tobacco in any form? Yes No If yes, how much? _____ For how long? _____

ALLERGIES - Circle any and all of the following to which you are allergic:

Aspirin • Barbiturates/Sleeping Pills • Codeine • Anesthesia • Erythromycin • Ibuprofen/Motrin • Jewelry/Metals • Latex • Percocet • Penicillin • Tetracycline • Vicodin

Please list any other medications and/or materials to which you think you are allergic: _____

MEDICAL CONDITIONS

Have you ever had any of the following medical conditions? Circle "Yes" or "No."

Abnormal Bleeding	Yes	No	Frequent Headaches	Yes	No	Mitral Valve Prolapse	Yes	No
Alcohol or Drug Abuse	Yes	No	Glaucoma	Yes	No	Pacemaker	Yes	No
Anemia	Yes	No	Hay Fever	Yes	No	Psychiatric Problems	Yes	No
Arthritis	Yes	No	Heart Attack	Yes	No	Radiation Treatment	Yes	No
Artificial Bones/Joints/Valves	Yes	No	Heart Murmur	Yes	No	Rheumatic/Scarlet Fever	Yes	No
Asthma	Yes	No	Heart Surgery	Yes	No	Seizures	Yes	No
Blood Transfusion	Yes	No	Hemophilia	Yes	No	Shingles	Yes	No
Cancer/Chemotherapy	Yes	No	Hepatitis	Yes	No	Sickle Cell Disease/Traits	Yes	No
Colitis	Yes	No	Herpes/Fever Blisters	Yes	No	Sinus Problems	Yes	No
Congenital Heart Disease	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	HIV or AIDS	Yes	No	Thyroid Problems	Yes	No
Difficulty Breathing	Yes	No	Hospitalized for Any Reason	Yes	No (If yes, please explain below.)			
Emphysema	Yes	No	Kidney Problems	Yes	No	Tuberculosis/TB	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No	Ulcers	Yes	No
Fainting Spells	Yes	No	Low Blood Pressure	Yes	No	Venereal Disease	Yes	No

Please explain any serious medical conditions you have ever had: _____

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DENTAL HISTORY

Why have you come to our office today? _____ Are you in pain? Yes No If yes, for how long? _____

Previous Dentist/Dental Office Name: _____ Phone: _____ Last Visit Date: _____

What was done? _____ Date of Last Cleaning: _____ Date of Last Dental X-rays: _____

Have you ever been told that you require antibiotics prior to receiving dental treatment? Yes No

Do you have or have you ever had any of the following conditions, ailments, or treatments? Circle "Yes" or "No."

Bad Breath	Yes	No	Food Collection Between Teeth	Yes	No	Orthodontic Treatment	Yes	No
Bleeding Gums	Yes	No	Foreign Objects in Mouth	Yes	No	Pain Around Ear	Yes	No
Blisters on Lips or in Mouth	Yes	No	Grinding Teeth	Yes	No	Pain When Brushing	Yes	No
Broken Fillings	Yes	No	Gums Swollen or Tender	Yes	No	Periodontal Treatment	Yes	No
Burning Sensation on Tongue	Yes	No	Jaw Fatigue	Yes	No	Sensitivity to Cold	Yes	No
Chew on Only One Side	Yes	No	Jaw Pain	Yes	No	Sensitivity to Heat	Yes	No
Clenching of Teeth	Yes	No	Lip or Cheek Biting	Yes	No	Sensitivity to Sweets	Yes	No
Clicking or Popping of Jaw	Yes	No	Loose Teeth	Yes	No	Sensitivity When Chewing	Yes	No
Dry Mouth	Yes	No	Mouth Breathing	Yes	No	Sores or Growths in Mouth	Yes	No

Is snoring a problem for you? Yes No Do you feel you may need braces or a retainer at this time? Yes No Do you use an electric toothbrush? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No Do you ever experience pain in your jaw joint (TMJ/TMD)? Yes No

How would you classify your current dental health? Excellent Good Fair Poor Very Poor

On a scale of 1-10, how would you rate your smile (10 being the best)? 1 2 3 4 5 6 7 8 9 10

Would you like whiter teeth? Yes No Would you like fresher breath? Yes No What else about your smile would you like to change? _____

Do you feel anxiety about dental treatment? Yes No On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? 1 2 3 4 5 6 7 8 9 10

On average, how many times a day do you brush? _____ How many times a week do you floss? _____ What type of bristles does your toothbrush have? Soft Medium Hard

THIS SECTION WILL BE COMPLETED BY THE DENTIST

Summary of Dental History:

_____

_____

Summary of Medical History:

_____

_____

MEDICAL HISTORY UPDATES - TO BE COMPLETED AS NEEDED & INITIALED BY PATIENT & STAFF

Date:	Comments:	INITIALS Patient	Dentist	Hygienist
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

OSHA

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the American Dental Association.

AUTHORIZATION & RELEASE OF INFORMATION

- I authorize Andrew J. Holloman, DDS & Associates to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to the third party payors and/or other health practitioners. Any records released at the patient's request are subject to duplication fees.
- I authorize and request my insurance company to pay directly to Andrew J. Holloman, DDS & Associates insurance benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered for me or for my dependent(s).

_____ _____

Signature of Patient (or Parent/Guardian of Patient) Date

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PAYMENT OPTIONS

For your convenience, we offer the following payment options. Please circle the option you prefer below:

Cash Personal Check Visa MasterCard I wish to discuss the financial policies

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in your being unable to provide additional dental services except for dental emergencies, or where there is prepayment for additional dental services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

PATIENT OR GUARDIAN INITIALS____

AUTHORIZATION & RELEASE FOR GENERAL RISKS ASSOCIATED WITH DENTAL TREATMENT

Thank you for choosing Andrew J. Holloman, DDS & Associates for your dental care. We hope to work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has inherent risks. These are seldom great enough to offset the benefits of treatment but should still be considered when making treatment decisions. Benefits of dental treatment include: relief of pain, the ability to chew properly and enjoy eating, and the confidence and social interaction that a pleasing smile can bring. Common risks associated with virtually any dental procedure include:

- Local anesthetic. The use and administration of anesthetic agents embodies certain risks including, but not limited to: drug and allergic reactions; side effects such as racing heart or prolonged and, in rare instances, permanent numbness to lips, tongue, cheek, or eye; bruising, swelling, and pain at injection site; difficulty opening the mouth, and/or jaw (TMJ) pain.
- Allergic reaction. Dental materials and medications may trigger allergic or sensitivity reactions.
- Muscle or joint tenderness. Holding one's mouth open for prolonged periods of time, such as during dental treatment, can result in muscle or jaw joint tenderness. In a predisposed patient, it can precipitate a TMJ disorder.
- Sensitivity in or damage to teeth or gums, infection, or bleeding.
- Swallowing or inhaling small objects.

We follow procedural guidelines that most often lead to clinical success but, as in any other pursuit in health care, not everything always turns out the way it is planned. We will do our best to ensure that it does. Please feel free to ask questions in regards to any and all dental procedures that are recommended to you for yourself or for your dependent(s).

CONSENT TO BASIC DENTAL CARE

I, the undersigned patient or guardian, hereby authorize the treating doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my/the patient's dental needs. Should I agree to further routine dental care, I authorize the doctor and/or hygienist to perform any treatment, apply medications, and utilize therapies that are routine in nature, with my verbal consent. More advanced treatments will carry additional consent and information forms to sign. I also authorize and consent that the doctor choose and employ such assistance as deemed fit.

My signature below indicates that I have read and understand the general risks associated with dental treatment.

Signature of Patient (or Parent/Guardian of Patient) Date

CLOSING NOTE

We will be happy to provide you with additional financial information at your complimentary Treatment Plan Consultation. If you have any further financial questions, please don't hesitate to ask us. Our office policies have been created to facilitate communication and to avoid misunderstandings. Please feel free to contact us about any questions or concerns you might have about your dental care. We appreciate your trust and confidence, and we thank you for the opportunity to provide your dental care.

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Page 5 - *Thank You!*

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my dental treatment and follow-up care among the multiple health care providers and professionals who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal health care operations, including quality assessments and physician certification.

I acknowledge having received, read, and understood the Notice of Privacy Practices containing a more complete description of the uses and disclosers of my health information. I understand that Andrew J. Holloman, DDS & Associates have the right to change the Notice of Privacy Practices from time to time, and that I may contact Andrew J. Holloman, DDS & Associates at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Andrew J. Holloman, DDS & Associates are not required to agree to my requested restrictions, but that formally agreed upon restrictions are legally binding.

Patient Name: _____

Patient's Parent/Guardian Name (If applicable): _____

Signature of Patient (or Parent/Guardian of Patient): _____

Date: _____

If there is there someone you would like us to discuss your treatment with, please provide the following information:

Name: _____ Relationship: _____ Phone:_____

_____ _____

Signature of Patient (or Parent/Guardian of Patient) Date

FOR OFFICE USE ONLY

I attempted to obtain the patient's/patient guardian's signature to acknowledge receipt of the Notice of Privacy Practices but was unable to do so as documented in the blank space below:

_____

Signature of Andrew J. Holloman, DDS & Associates Staff Date