Coastal Dental Services <<<>>> Dentures & *More*

Southside Office

4402 Old Salisbury Road

Jacksonville, Florida 32216

Tele: (904) 296-7757 <<<>>> Fax: (904) 296-0147

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Confidential Personal Information and Medical & Dental History*(Page 1 of 5)*

PERSONAL INFORMATION QUESTIONNAIRE

Optimum health service is our dedicated objective. In order to render this service with excellence and safety it is necessary to become acquainted with vital information related to each patient. The following "Personal Information" & the "Confidential Medical History" questionnaires are therefore important to your dental treatment in this office. Please take care to carefully and truthfully answer every question on these forms. If you need more space, please use the third sheet to supplement your answers or to provide additional required information. Your answers to these questions are confidential and will be for this office's use to aid in your treatment.

PATIENT NAME:____BIRTHDATE:__________SSN:__________
First Initial Last Name

MAILING ADDRESS:______________________________CITY:________________STATE________ ZIP:__________

RESIDENCE PHONE:____________FAX:____________CELL:____________E-MAIL:__________________________

YOUR OCCUPATION:___________________EMPLOYER________________________WORK PHONE:____________
(Business name if self employed)

SPOUSE, PARENT or NEAREST OF KIN:________________________________ EMERGENCY PHONE #:____________

SPOUSE OCCUPATION:_________________EMPLOYER________________________WORK PHONE:____________
(Business name if self employed)

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT______________________________________SSN:__________

FORMER DENTIST:____________________TOWN:_______________ TELEPHONE:____________FAX:___________

APPROXIMATE DATE OF LAST VISIT:__________TREATMENT RENDERED:__________________________________

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?____

HAVE YOU SEEN OUR ADVERTISEMENT:

IN THE YELLOW PAGES? ☐ ; THE FL TIMES-UNION? ☐ ; H-MAGAZINE? ☐ ; HEALTH SOURCE? ☐ ;

WEBSEARCH? ☐ ; FLDENTAL.COM? ☐ ; RADIO? ☐ ; TV? ☐ ;OTHER?_________________________

METHOD OF PAYMENT: CASH ☐ , CHECK ☐ , MEDICAID ☐ , VISA/MASTERCARD/DISCOVER ☐

DO YOU HAVE DENTAL INSURANCE? Yours: ◘ , or Spouse's: ◘ . IF SO, POLICY OWNER'S SS#__________

NAME OF POLICY_________________________ GROUP/EMPLOYER'S NAME________________________________
(If you have insurance, please provide insurance information/card & ***completed and signed claim forms*** when turning in this form – if you have insurance, please advise the receptionist – she will give you the Office's Insurance Policy form. Please read and familiarize yourself with this policy.)

IF YOU ARE HAVING DENTURES ☐ PARTIALS ☐ IS THIS THE INITIAL PLACEMENT? Yes ◘ No ◘

IF NOT INITIAL PLACEMENT, DATE OF PRIOR PLACEMENT: Month:________ Year:__________

I hereby attest to the information listed above as to its accuracy and correctness – If there is any change in my health or medications, I will inform the doctor or his assistant prior to any treatment. By signing this form I authorize release of medical information to associated medical/dental providers, insurance companies of which I am an insured, &/or other entities legally authorized by Florida State Law to possess my medical/dental treatment & condition records.

Signature:____ Date:_________________