



W E L C O M E

JUNO BEACH RESTORATIVE & AESTHETIC DENTISTRY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

GREG K. RILEY D.M.D., P.A. • DUANE E. KEUNING, D.M.D., P.A.

PATIENT INFORMATION

Date _____ Home Phone _____ Cell _____ Soc. Sec. # _____

Name _____ Drivers License # _____ / State _____
Last Name First Middle

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Full Time Part Time Retired Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Are you a year-round resident of Florida? Yes No If no, which months are spent in Florida. _____

In case of emergency who should be notified? _____

Has anyone in your family ever been a patient here? Yes Name _____ No E-mail address _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

Address _____
City State Zip

Date of last dental care _____ Date of last dental X-rays _____

Check (✓) if you have had problems with any of the following:

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity to hot
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Sensitivity when biting
<input type="checkbox"/> Food collection between teeth	<input type="checkbox"/> Sensitivity to cold	<input type="checkbox"/> Sores or growths in your mouth

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

Have you had any serious problems associated with previous dental treatment? Yes No

If so, explain _____

Do you gag easily? _____ Yes No

Do you wear dentures? _____ Yes No How many years _____

PERMISSION/DOCTOR'S NOTES

PERMISSION FOR TREATMENT: This is to certify that I, the undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetic and X-rays as indicated. I will assume responsibility for fees associated with those procedures. I also certify that all information I have provided on this form is correct.

Patient signature

Doctor's Notes:

MEDICAL HISTORY

Physician's Name _____ Phone # _____ Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No

Taking birth control pills? Yes No

Check (✓) if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Abnormal blood pressure | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Coumadin Therapy | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Medical Implants | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Metal Allergies | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit/Smoking |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis or Lung Disease |
| <input type="checkbox"/> Circulatory Problems | Describe _____ | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer |
| | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |

Do you take:

- Aspirin Vitamins Herbs Minerals

MEDICATIONS / DOSAGE

List medications you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES

PRIMARY INSURANCE

Person Responsible for Account _____ Relation to Patient _____

Birthdate _____ Last Name _____ FIRST _____ Middle _____ Soc. Sec.# _____ Phone _____

Address (if different from patient's) _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered by this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec.# _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered by this plan _____

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for service 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. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due at time of treatment unless prior arrangements are made.