PATRICK CHASE, D.D.S.

6161 DR. MARTIN LUTHER KING, JR. STREET NORTH, SUITE 103

ST. PETERSBURG, FL 33703

TELEPHONE: (727) 527-4955 FAX: (727) 526-5716

Date_____

PATIENT:_____BIRTHDATE:_____

Home Address:_____Phone:_____City_____ State _____Zip_____

Patient Employed by: _____ Occupation_____

Business Address:_____ Soc Sec # _____

City:_____ State:_____ Zip:_____ Business Phone: _____

E-Mail Address:_____ How do you want apts confirmed: Hm:_____ Wk:_____ Email:_____

Name of Spouse:_____ Spouse Employed by: _____Occupation: _____

Business Address_____ City: _____State:_____ Business Ph:_____

Patient Referred By: _____ Name of Responsible Party: (if minor) _____

Address: _____ City:_____ State: _____Zip: _____

Dental Insurance:_____ I authorize Dr. Chase and staff to use my Personal Health Information (PHI) as needed, to file my insurance for me. Please Sign: _____

INSURANCE: To avoid any misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and the patient is personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for individual patient.

MEDICAL HISTORY:

Have you ever been treated for any of the following: Please indicate yes or no for each

Heart Disease_____ Heart Valve Problems _____ Hepatitis_____ Cancer_____

High Blood pressure_____ Anemia_____ Blood Transfusion _____ Liver/Kidney Disease _____

Organ Transplant _____ Diabetes_____ Hip or Joint Replacement _____ Rheumatic Fever_____

Other _____ Are you pregnant or nursing? _____ Are you taking any medicine now? Yes /No

If so what? _____

Have you a tendency to prolonged bleeding? Yes_____ No_____ Are you allergic to Penicillin_____ Anesthetic _____Other_____

Are you under your physician's care for any reason? Yes_____No_____ Do you have regular physical check-ups? Yes _____No_____

Physician's Name_____ Telephone #_____

Did you see your former dentist regularly? Yes _____No_____ How long since your last dental appointment? _____

Chief Dental Complaint:_____History_____

Signature:_____