Jason Manchester, D.M.D.
3830 Highway A1A, Suite 1
Melbourne Beach, FL 32951

Medical Alert For Office Use

Thank you for visiting our dental office! We want your visit to be pleasant and comfortable. Please help us by completing this form. If you need assistance, please let us know. We will be happy to help!

PATIENT INFORMATION

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET CITY STATE ZIP

Employer _____ Drivers License # _____

Birth date _____ Email _____

Phone: Home (____) _____ Social Security # _____

Work (____) _____ May we contact you at work? ❑ Yes ❑ No

Mobile (____) _____ ❑ Male ❑ Female

Emergency Contact: _____ Phone (____) _____

Name of Person Responsible for This Account (if other than patient) _____

Address _____ Phone Number _____

Relationship to Patient _____ Birth Date _____ Social Security # _____

INSURANCE INFORMATION

Subscriber Name _____ Social Security # _____

Relationship to Patient _____ Birth Date _____ Phone # (____) _____

Employer _____ Insurance Company _____

Insurance Co. Phone # _____ Group # _____

Secondary Dental Insurance Carrier

Subscriber Name _____ Social Security # _____

Relationship to Patient _____ Birth Date _____ Phone # (____) _____

Employer _____ Insurance Company _____

Insurance Co. Phone # _____ *Group #* _____

TREATMENT AUTHORIZATION STATEMENT

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also agree to pay for all services rendered by this office, and understand that I am ultimately responsible for all charges on my account.

Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Patient Health/Dental History

Patient: _____ Date: _____

This information is vital to allow us to provide appropriate care for you. Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following thoroughly and honestly.

Are you under a physician's care now? ☐YES ☐NO If yes, for what? _____
Date of last physical exam: _____ _____

Have you ever been hospitalized or had a major operation? ☐YES ☐NO If yes, for what? _____ _____

Have you ever had a serious head or neck injury? ☐YES ☐NO If yes, explain _____

Do you have a joint replacement? Knee? Hip? What year? ☐YES ☐NO If yes, explain _____ _____

Do you take, or have you taken, Phen-Fen or Redux? ☐YES ☐NO If yes, explain _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐YES ☐NO If yes, explain _____ _____

Do you drink or have an alcohol dependency? ☐YES ☐NO If yes, explain _____

Have you previously or do you currently use tobacco? Smoke? Chew? ☐YES ☐NO If yes, explain _____ _____

Do you use controlled substances or have a drug addiction? ☐YES ☐NO If yes, explain _____ _____

WOMEN ONLY, are you… ☐ **Pregnant/Trying to get pregnant** ☐ **Nursing** ☐ **Taking oral contraceptives**

Are you allergic to any of the following?

☐ Aspirin/Ibuprofen/Acetaminophen ☐ Penicillin or other antibiotics ☐ Codeine or other narcotics ☐ Acrylic ☐ Fluoride
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local anesthetics Any other allergies? List here _____

Do you have, or have you had, any of the following? Please circle YES or NO

Abnormal Bleeding	YES	NO	AIDS/HIV positive	YES	NO	Alzheimer's Disease	YES	NO	Anaphylaxis	YES	NO
Anemia	YES	NO	Angina	YES	NO	Arthritis/Gout	YES	NO	Artificial Heart Valve	YES	NO
Artificial Joint	YES	NO	Asthma	YES	NO	Autoimmune Disease	YES	NO	Back Problems	YES	NO
Blood Disease	YES	NO	Blood Transfusion	YES	NO	Breathing Problems	YES	NO	Bruise Easily	YES	NO
Cancer	YES	NO	Chemotherapy	YES	NO	Chest Pains	YES	NO	Cold Sore/Fever Blisters	YES	NO
Congenital Heart Disorder	YES	NO	Convulsions	YES	NO	Cortisone Medicine	YES	NO	Diabetes	YES	NO
Drug Addiction	YES	NO	Easily Winded	YES	NO	Eating Disorder	YES	NO	Emphysema	YES	NO
Epilepsy or Seizures	YES	NO	Excessive Bleeding	YES	NO	Excessive Thirst	YES	NO	Faint Spells/Dizziness	YES	NO
Frequent Cough	YES	NO	Frequent Diarrhea	YES	NO	Frequent Headaches	YES	NO	Genital Herpes	YES	NO
Glaucoma	YES	NO	Hay Fever	YES	NO	Heart Attack/Failure	YES	NO	Heart Murmur	YES	NO
Heart Pacemaker	YES	NO	Heart Trouble/Disease	YES	NO	Hemophilia	YES	NO	Hepatitis A	YES	NO
Hepatitis B or C	YES	NO	Herpes	YES	NO	High Blood Pressure	YES	NO	High Cholesterol	YES	NO
Hives or Rash	YES	NO	Hypoglycemia	YES	NO	Irregular Heartbeat	YES	NO	Jaundice	YES	NO
Kidney Problems	YES	NO	Leukemia	YES	NO	Liver Disease	YES	NO	Low Blood Pressure	YES	NO
Lung Disease	YES	NO	Mental Health Disorder	YES	NO	Mitral Valve Prolapse	YES	NO	Neurological Disorder	YES	NO
Osteoporosis	YES	NO	Pain in Jaw Joints	YES	NO	Parathyroid Disease	YES	NO	Psychiatric Care	YES	NO
Radiation Treatments	YES	NO	Recent Weight Loss	YES	NO	Renal Dialysis	YES	NO	Rheumatic Fever	YES	NO
Rheumatism	YES	NO	Scared of Dentist	YES	NO	Scarlet Fever	YES	NO	Shingles	YES	NO
Sickle Cell Disease	YES	NO	Sinus Trouble	YES	NO	Spina Bifida	YES	NO	Stomach/Intestinal Disease	YES	NO
Stroke	YES	NO	Swelling of Limbs	YES	NO	Thyroid Disease	YES	NO	Tonsillitis	YES	NO
Tuberculosis	YES	NO	Tumors or Growths	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO

Have you ever had any serious illness not listed above or anything else we need to know? ☐ YES ☐ NO
If yes, explain _____

Are you taking any Medications/Pills/Drugs ☐ **YES** ☐ **NO** **If yes, please list below. Ask for additional sheet if needed.**

DRUG	PURPOSE	DRUG	PURPOSE

How would you rate the condition of your mouth? ☐Excellent ☐Good ☐ Fair ☐Poor
Previous Dentist _____ How long have you been a patient? _____ months/years
When was your last dental exam? _____ When did you last have X-rays taken? _____
I routinely see my dentist every ☐3 months ☐ 6 months ☐ 12 months ☐not routinely
WHAT IS YOUR IMMEDIATE CONCERN?_____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING: **RISK LEVEL (admin only)**

PERSONAL HISTORY ☐LOW ☐MED ☐HIGH

Are you fearful of dental treatment? Scale of 1 to 10 (very)_____ YES NO
Have you had an unfavorable dental experience? _____ YES NO
Have you ever had complications from past dental treatment? _____ YES NO
Have you ever had trouble getting numb or reactions to local anesthetic? _____ YES NO
Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
Have you had any teeth removed?_____ YES NO

TOOTH STRUCTURE ☐LOW ☐MED ☐HIGH

Have you had any cavities within the past 3 years? _____ YES NO
Do you have a dry mouth? _____ YES NO
Are any teeth sensitive to hot, cold, biting or sweets? _____ YES NO
Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?_____ YES NO
Do you avoid brushing any part of your mouth? _____ YES NO
Do you feel or notice any holes (i.e.pitting) in your teeth? _____ YES NO

BITE AND JAW JOINT ☐LOW ☐MED ☐HIGH

Do you/would you have any problems chewing gum? _____ YES NO
Do you/would you have any problems chewing bagels or other hard foods? _____ YES NO
Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ YES NO
Are your teeth crowding or developing spaces? _____ YES NO
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?_____ YES NO
Do you have any problems with sleep or wake up with an awareness of your teeth?_____ YES NO
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
Do you grind your teeth?_____ YES NO
Do you wear or have you ever worn a bite appliance? _____ YES NO

GUM AND BONE ☐LOW ☐ MED ☐HIGH

Have you ever been diagnosed or treated for periodontal (gum) disease? _____ YES NO
Have you ever experienced gum recession? _____ YES NO
Is there anyone with a history of periodontal disease in your family? _____ YES NO
Do your gums bleed when brushing, flossing or eating? _____ YES NO
Are your teeth becoming loose? _____ YES NO
Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO

SMILE CHARACTERISTICS ☐LOW ☐ MED ☐HIGH

Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
Have you ever whitened (bleached) your teeth? _____ YES NO
Are you self-conscious about your teeth? _____ YES NO
Have you been disappointed with the appearance of previous dental work? _____ YES NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing Incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in dental/medical status or any changes in medications taken.

Signature of Patient _____ Date _____ Doctor's Signature _____

Jason Manchester, D.M.D
Nigel Shultz, D.M.D

A1A Smiles, PA
3830 Highway A1A, Suite 1
Melbourne Beach, FL 32951
(321)728-0025

Office Policies

Welcome to our dental office! We are thrilled that you have chosen us to provide your dental care needs! At our office, we are committed to providing the highest quality care possible. Please read over our policies and sign below. Thank you!

Financial Policy: Payment is due in full at the time of service, upon completion of your visit. We will try to accurately estimate our fees but due to the nature of dental treatment, we can only estimate. We will make you aware of any changes in treatment before we continue. All fees quoted are for 90 days only and we can provide a printed estimate upon request.

Insurance: If you have dental insurance, we will do our best to maximize your benefits! We are an out-of-network provider, so we can get an ESTIMATE of what your insurance may cover, but it will only be an estimate. What insurance companies pay varies greatly from policy to policy and we have no control over how, what, or when they will pay. At your appointment, you will owe the estimated patient portion and as a courtesy, we will file the claim electronically for you. If insurance pays less than expected, you will be responsible for the remaining balance. Ultimately, you are responsible for your account and your dental insurance. If your dental insurance does not pay within 60 days, we will expect you to pay the total amount due.

Cancelled/Missed Apppointments: We appreciate your busy schedule and are committed to reserving an appointment time that works for you. We are also committed to being ready for you at your appointment time with little to no wait. We appreciate your effort in getting to your appointments on time in order to complete the services planned for that day. If you are unable to keep your scheduled appointment, we ask that you promptly call to reschedule. Patients who cancel without 24 hour notice, or who do not show up for the appointment will be charged a $45.00 fee.

Personal Health/Dental Information: Our office would like to call and leave a message on your phone number on file regarding upcoming appointments and/or confirmations. Please indicate below if you do not want us to leave messages:

☐ DO NOT LEAVE MESSAGES REGARDING UPCOMING APPOINTMENTS AND/OR CONFIRMATIONS

☐ DO NOT SHARE ANY OF MY INFORMATION WITH ANYONE OTHER THAN MYSELF

If you would like to give permission to someone other than yourself with whom we can discuss your appointments with, please list them below.

Name of Person _____ Relationship _____

Name of Person _____ Relationship _____

I acknowledge that I have read and understand the information provided above, and I agree to pay for all services rendered by this office.

Patient Name _____

Patient Signature _____ Date _____

Jason Manchester, D.M.D, FAGD

A1A Smiles, PA
3830 Highway A1A, Suite 1
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(321)728-0025

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

_____

_____