Kevin G. Snyder, D.D.S., P.A.

Patient Information

Patient Name:_____
First Middle Initial Last
Preferred Name:_____
Sex: M F Married Single Child Other
D.O.B.:_____SS#:_____
Driver License#:_____
Address:_____
City, State and Zip:_____
E-Mail:_____
Employer:_____
Spouse's Name:_____
D.O.B.:_____SS#:_____
Spouse's Employer:_____

Responsible Party: (If a Minor)

Name:_____
Employer:_____
D.O.B.:_____ SS#:_____

Whom may we thank for referring you?_____

Phone Numbers:

Home:(___)_____Work:(____)_____Ext:_____
Cell:_____Spouse/Parent Cell phone:_____

In case of emergency, contact:
Name:_____Relationship:_____
Home Phone:(_____)_____Cell Phone:(____)_____

Preferred Pharmacy: (Name & City)_____

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www.kevinsnyderdds.com info@kevinsnyderdds.com

6173 W. Gulf To Lake Hwy. • Crystal River, FL 34429 (352)795-1074

Medical & Dental History Form

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

What is the reason for your dental visit today?

If you could change one thing about your teeth or smile, what would it be?

Are you having pain or discomfort at this time? ◯ Yes ◯ No

Do you feel nervous about dental treatment? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

If you answered yes to previous question please explain below.

Your Primary Care Physician's name, phone number and the approximate date of your last medical exam?

Please list any medications you are currently taking, one medication per line:

Are you allergic to (i.e., itching, rash, swelling of the hands, feet or eyes) or made by sick by penicillin, aspirin, codeine, or any drugs or medications?

◯ Yes ◯ No

If so, to what?

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

Please mark any of the following to indicate Yes in response to the question:

- ☐ When you walk up the stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are tired?
- ☐ Do your ankles swell during the day?
- ☐ Have you lost or gained more than 10 pounds in the last year?
- ☐ Do you wake up from sleep with shortness of breath?
- ☐ Are you on a special diet?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

_____

_____

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?

☐ Acid Reflux/GERD	☐ Allergies (Seasonal)	☐ Alzheimer's/Dementia	☐ Anemia
☐ Angina	☐ Anxiety	☐ Arthritis	☐ Artificial Joints
☐ Aspirin Allergy	☐ Asthma	☐ Atrial Fibrillation	☐ Auto Immune Disorder
☐ Blood Disease	☐ Blood Thinner	☐ Cancer	☐ Cerebal Palsy
☐ Chemotherapy	☐ Chronic Fatigue	☐ Cipro Allergy	☐ Claustrophobic
☐ Codeine Allergy	☐ Cold Sores	☐ Defibrillator	☐ Diabetes
☐ Drug/Alcohol Addict	☐ Epilepsy	☐ Erythromycin Allergy	☐ Excessive Bleeding
☐ Eye Implants	☐ Fainting	☐ Fibromyalgia	☐ Glaucoma
☐ HIV	☐ Head Injuries	☐ Headaches/Migraines	☐ Hearing Problems
☐ Heart Disease	☐ Heart Failure	☐ Heart Murmur	☐ Heart Surgery
☐ Heart Valve Replacement	☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C
☐ Hepatitis D	☐ High Blood Pressure	☐ High/Low Cholesterol	☐ Keflex/Ceph Allergy
☐ Kidney Disease	☐ Latex Allergy	☐ Liver Disease	☐ MVP
☐ Mental Disorders	☐ Nervous Disorders	☐ Neurological	☐ Osteoporosis
☐ Pacemaker	☐ Pain In Jaw Joints	☐ Parkinson's Disease	☐ Penicillin Allergy
☐ Pregnancy	☐ Premed	☐ Prostate	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ Scarlet Fever
☐ See Notes	☐ Seizures	☐ Sinus Problems	☐ Stomach Problems
☐ Stroke	☐ Sulfa Allergies	☐ Tetracycline Allergy	☐ Thyroid Disease
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Veneral Disease
☐ Vitamin D Deficiency	☐ Watchman Device		

FOR OFFICE USE ONLY

_____

_____

_____

_____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

o Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment;

o Obtaining payment from third party payers (e.g. my insurance company);

o The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request certain restrictions on how my protected health information is used and dissclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do not agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Please list by name any other people you are authorizing to receive your protected dental information.

_____

_____

Patient Dental Benefit Information

As a courtesy to our patients, our office will assist you in obtaining the maximum benefit from your insurance. However, there are some common misconceptions about dental insurance benefits of which you should be aware of.

1. The term dental insurance is actually a misnomer. Insurance traditionally has meant the consumer pays a preset deductible and your insurance pays the remaining balance. A more correct term would be dental benefits or supplement to aid in offsetting the out-of-pocket expense accrued by the patient. This expense, called the copayment is due at the time the service is rendered.

2. Dental benefits pay based on a premium paid by you or your employer. Higher premiums pay more of the fees charged, have fewer exclusions, are less restrictive and ultimately result in less out-of-pocket expenses for the patient. If you believe your benefit should pay more on a particular procedure it may be beneficial to contact your insurance regarding this issue not us. Again, we did not set the standards or choose the plan in which you participate.

3. We do not accept secondary insurances, Workman's Compensation, Homeowner's or Automobile Insurance claims. All of these will be paid in full at time of service by the patient and the patient shall seek reimbursement. We will assist you in filing your claim by giving you the necessary information related to your particular case.

4. Any and all insurance balance over 60 days is considered delinquent and must be paid immediately by the patient. It then becomes up to you to receive reimbursement for any benefits due to you.

Response Date: _____