ISLAND COAST DENTISTRY

Jeffrey Skupny D.M.D.
1044 Castello Drive, Suite 110
Naples, FL 34103
Tel: 239-261-5566 Fax: 239-262-5803
www.IslandCoastDentistry.com

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care, please complete this form.

Patient Name:	**Date:**

What is your reason for your visit today?

Previous Dentist's Name:	Phone #:		
Northern Dentist's Name:	Phone #:	E-mail:	
Address:	City:	State:	Zip:

Date of last dental visit:	Last dental hygiene visit:
Complete set of x-rays: (16 to 18 films)	
How often do you have dental visits?	
How often do you brush your teeth?	
How often do you floss?	

Do you have any dental concerns now	Yes	No
If yes, please describe :		
Are any of your teeth sensitive to :		
Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing ?	Yes	No
Have you noticed any mouth odors or bad taste?	Yes	No
Do you gums bleed or hurt ?	Yes	No
Have you experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth? If yes, where?	Yes	No
Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
(pencils, pipe, pins, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment ?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head ? If so, please describe , including cause.	Yes	No
Have you experienced :		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Are you satisfied with your teeth's appearance ?	Yes	No
Would like to keep all of your teeth all of your life?	Yes	No

Have you ever had an upsetting dental experience? If yes, please describe:

Do you feel nervous about having dental treatment? If so, what is your biggest concern?

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PATIENT MEDICAL HISTORY

Patient's Name:				**Today's Date:**	
		E-mail Address:			
Address:				**Year-round resident:**	**Y N**
City, State, Zip:					
Home Phone:		**Cell Phone:**		**Work Phone:**	
Birth Date:		**Social Security No:**		**Marital Status:**	
Person to contact in case of emergency & phone #:				**Whom may we thank for referring you?**	
Primary Dental Guarantor:				***Please provide Dental Insurance Card***	
Physician Name:				**Physician Phone:**	
Sex: M F		**If female, please answer the following:**			

Y	**N**	**Are you taking Birth Control pills?**		
Y	**N**	**Are you pregnant?**	**If yes, # of weeks**	
Y	**N**	**Are you nursing?**		

Y	**N**	**Do you smoke or use tobacco?**

Y	**N**	**Conditions**	**Y**	**N**	**Conditions**	**Y**	**N**	**Conditions**
		Abnormal Bleeding			Glaucoma			Stroke
		Alcohol /Drug Abuse			Diet restricted/special			Thyroid Problems
		Allergies/ Seasonal			Heart Attack			Tuberculosis
		Angina Pectoris			Heart Surgery			Ulcers
		Arthritis			Hemophilia			Venereal Disease
		Artificial Heart Valve			Hepatitis A / B / C			Atrial Fibrillation
		Asthma			Sleep apnea			Other medical conditions not listed:
		Anemia			High Blood Pressure			
		Blood Transfusion			HIV+AIDS			**Pre-med required Yes No**
		Cancer-Chemotherapy			Kidney Problems			
		Colitis			Joint Replacement			**Y N Allergies**
		Congenital Heart Defect			Liver Disease			Aspirin
		Cosmetic Surgery			Low Blood Pressure			Penicillin
		Diabetes			Mitral Valve Prolapse			Tetracycline
		Difficulty Breathing			Pace Maker/Difib			Codeine
		Emphysema			Pneumonia			Erythromycin
		Epilepsy			Psychiatric Care			Dental Anesthetics
		Fainting /Dizzy spells			Radiation Therapy			Jewelry
		Fever Blister/Cold Sores			Rheumatic Fever			Metals
		Frequent Headaches			Seizures			Latex
		GERD			Shingles			**Other**
		Contact Lenses			Sickle Cell Disease			
		Chronic Cough			Sinus Problems			

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Medications:	

Is there any disease,condition,or problem that you think this office should know about that is not covered above?

Yes	No	If yes please describe below....

If you have an alternate address, please let us know:

Notes:

Signature :_____ Date:_____

(if under 18, Parent or Guardian Signature Required)

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Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding any protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such ***Notices of Privacy Practices***. I understand that my dental provider has that right to change the ***Notice of Privacy Practices*** and that I may contact this office at the address above to obtain a current copy of the ***Notices of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Please list anyone else, who you would allow to have access to your records:

Name of persons: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement: _____

For office use only:

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reasons:

The patient refused to sign Communication barriers Emergency situation Other

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PAYMENT OPTIONS

- Payment is due in full on the day of service.

- Forms of payment include **cash, personal check, VISA, Master Card, American Express** and **Discover**.

- In order to facilitate access to the very best dental care possible, our office also participates with **Care Credit**. Care Credit offers short-term (6 months) interest free payment plans. (Patient access to Care Credit is available through their website www.Carecredit .com)

Dental Insurance: Because of the differences in polices regarding coverage and fee schedules, insurance benefits for services will be made directly to you, the insured, not to this office. The insurance company is responsible to you and not to our office. Therefore, please expect to make payment at the time of service.

We will be happy to assist you by filing your claims on the date of service, provided you supply us with the current, correct and necessary information. We will be happy to submit your treatment plan for pre-authorization upon your request. Once this has been returned to us, we will contact you by letter regarding your insurance benefits.

If you have any questions regarding your insurance, we ask that you contact your employer or insurance carrier regarding the specifics and details of the plan it is conducting on your behalf.

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jeffreyskupnydmd@gmail.com

Date: _____

To: _____

_____

_____

Please release records for the following patient (s) at the patient's request:

_____

_____

_____

_____

Please include the doctor's name, address, phone number and email address if possible.

Please accept this request for release of my records to the following office:

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Thank You.

_____
Patient Signature

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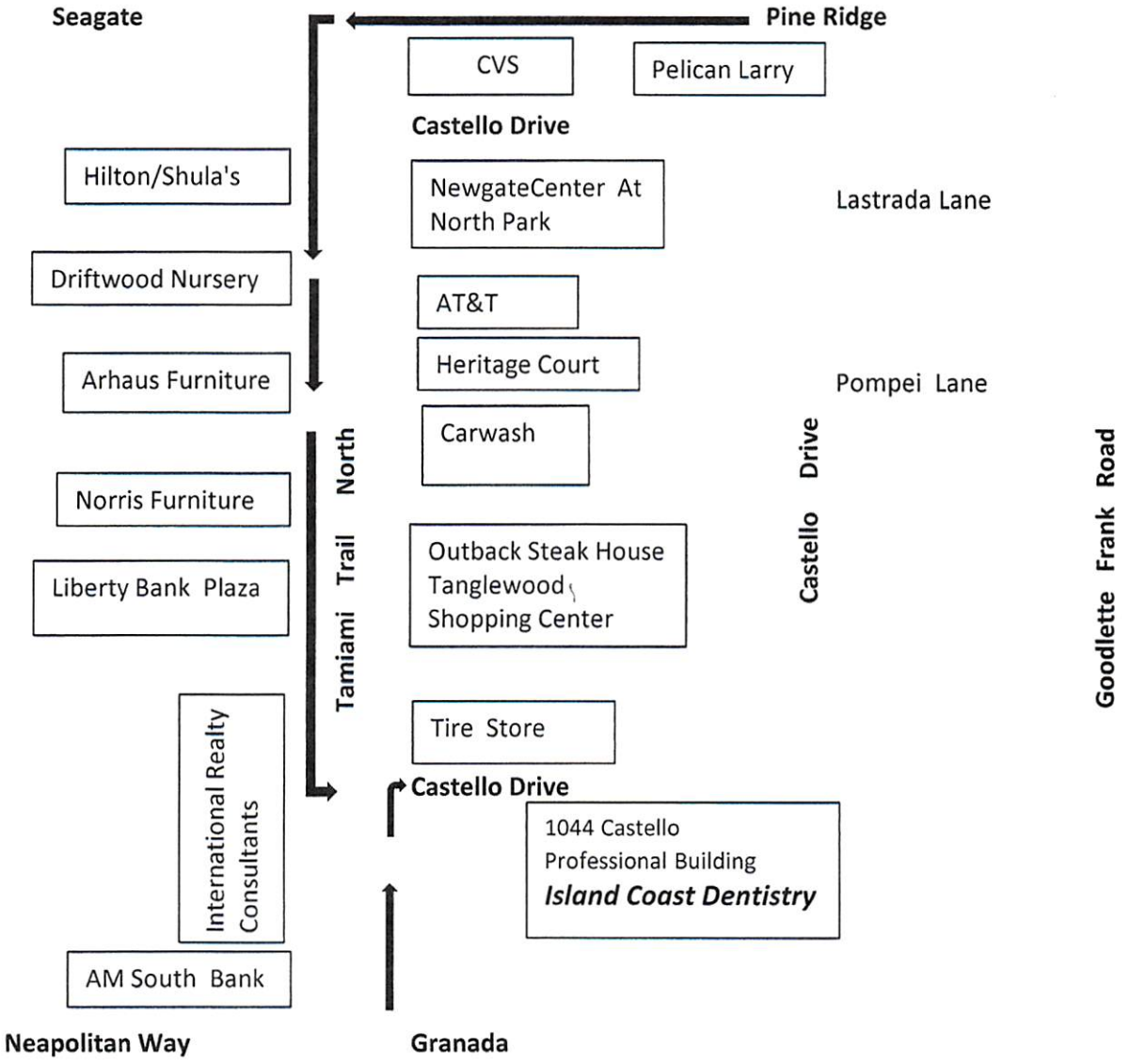

Directions:

From north of Pine Ridge Road : Travel south on US 41 past Pine Ridge Road, make 2nd left onto Castello Drive which is shortly after the car wash and the Tanglewood Plaza containing Outback Steakhouse. Take Castello Drive to the Castello Professional Center which is the second driveway on your right. Turn right into the parking lot.

From south of Pine Ridge Road: Travel north on US 41 past Neapolitan Way/Granada. Make a right turn onto Castello Drive. Make the second right into the parking lot of the Castello Professional Center.
1044 Castello Drive Suite 110.