Welcome to Alliance Dental Dr. Spaska Malaric, D.M.D.

Today's Date: _____/_____/_____

Name: _____,_____,_____
Last First MI

Preferred Name: _____Date of Birth: _____/_____/_____ ❑Male ❑Female

Address: _____

City: _____ State: _____ ZIP: _____

SSN: _____-_____-_____Cell Phone: _____

Home Phone: _____ Work Phone: _____

E-mail: _____

Employer: _____ Occupation: _____

How did you hear about our office? _____

Emergency contact name_____Phone Number_____

■ Insurance – Primary

Subscriber Name: _____Subscriber DOB: ____/____/_____

Subscriber SSN/ID: _____ Subscriber Employer:_____

Insurance Company Name: _____

Insurance Company Address:_____

Insurance Company Phone: _____ Group Number: _____

■ Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Alliance Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____Date: ____/____/_____

Medical History

Patient's Name: _____ Do you have a personal physician? ❑Yes ❑No

Physician's Name: _____Physician's Phone: _____Date of last visit: _____

Your current physical health is: ❑Good ❑Fair ❑Poor

Are you currently under the care of a physician? ❑Yes ❑No

If Yes, please explain: _____

Have you ever been hospitalized or had a major operation? ❑Yes ❑No, If Yes please explain_____

Have you ever had a serious head or neck surgery? ❑Yes ❑No

Do you use controlled substances? ❑Yes ❑No

Do you use recreational substances? ❑Yes ❑No

Do you use tobacco in any form? ❑Yes ❑No

Have you had any metal rods, pins or implants placed? ❑Yes ❑No

Are you taking any medications? ❑Yes ❑No

Please list each one: _____

Have you ever had any surgical procedures? ❑Yes ❑No

Please list each one: _____

Yes	No	Conditions
❑	❑	Abnormal bleeding
❑	❑	Alcohol abuse
❑	❑	Allergies
❑	❑	Alzheimer's disease
❑	❑	Anaphylaxis
❑	❑	Anemia
❑	❑	Angina Pectoris
❑	❑	Arthritis
❑	❑	Artificial Heart Valve
❑	❑	Artificial Joint
❑	❑	Asthma
❑	❑	Blood Transfusion
❑	❑	Blood disease
❑	❑	Bruise easily
❑	❑	Cancer
❑	❑	Chemotherapy
❑	❑	Chest pain
❑	❑	Cold sores
❑	❑	Colitis
❑	❑	Congenital Heart Defect
❑	❑	Convulsions
❑	❑	Cortisone medicine
❑	❑	Diabetes
❑	❑	Difficulty breathing
❑	❑	Drug abuse
❑	❑	Easily winded
❑	❑	Emphysema
❑	❑	Endocarditis
❑	❑	Epilepsy

Yes	No	Conditions
❑	❑	Excessive bleeding
❑	❑	Excessive thirst
❑	❑	Facial surgery
❑	❑	Fainting Spells
❑	❑	Fever Blisters
❑	❑	Frequent cough
❑	❑	Frequent diarrhea
❑	❑	Frequent headaches
❑	❑	Glaucoma
❑	❑	Jaw joint pain
❑	❑	Hay fever
❑	❑	HIV+ AIDS
❑	❑	Heart Attack
❑	❑	Heart Murmur
❑	❑	Heart pacemaker
❑	❑	Heart surgery
❑	❑	Heart Trouble disease
❑	❑	Hemophilia
❑	❑	Hepatitis A
❑	❑	Hepatitis B
❑	❑	Hepatitis C
❑	❑	Herpes
❑	❑	High blood pressure
❑	❑	Hives or rash
❑	❑	Hypoglycemia
❑	❑	Joint replacement
❑	❑	Irregular heart beat
❑	❑	Kidney problems
❑	❑	Leukemia

Yes	No	Conditions
❑	❑	Liver disease
❑	❑	Low Blood Pressure
❑	❑	Lung disease
❑	❑	Mitral Valve Prolapse
❑	❑	Osteoporosis
❑	❑	Parathyroid disease
❑	❑	Parkinson's disease
❑	❑	Pins, rods, stints or shunts
❑	❑	Pace Maker
❑	❑	Psychiatric problems
❑	❑	Radiation therapy
❑	❑	Recent weight loss
❑	❑	Renal dialysis
❑	❑	Rheumatic fever
❑	❑	Rheumatism
❑	❑	Scarlet fever
❑	❑	Seizures
❑	❑	Sexually Transmitted Disease
❑	❑	Shingles
❑	❑	Sickle cell disease
❑	❑	Sinus problem
❑	❑	Sleep apnea
❑	❑	Spina bifida
❑	❑	Stomach, Intestinal disease
❑	❑	Stroke
❑	❑	Swelling of limbs
❑	❑	Thyroid disease

Yes	No	
❑	❑	Tonsillitis
❑	❑	Tuberculosis
❑	❑	Tumors or growths
❑	❑	Ulcers
❑	❑	Yellow Jaundice

Allergies

- ❑ Acrylic
- ❑ Aspirin
- ❑ Barbiturates, sedatives, sleeping pills
- ❑ Codeine
- ❑ Dental anesthetics - Novocaine like medications
- ❑ Erythromycin
- ❑ Jewelry
- ❑ Latex
- ❑ Metals
- ❑ Milk protein
- ❑ Penicillin
- ❑ Sulfa drugs
- ❑ Tetracycline
- ❑ Other, please specify_____

- ❑ NO ALLERGIES

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____/_____/_____

Dental History

How may we help you today? _____ _____

Your current dental health is: ❑Good ❑Fair ❑Poor

Do you require antibiotics before dental treatment? ❑Yes ❑No Are you currently in pain? ❑Yes ❑No

Have you ever had gum treatment? ❑Yes ❑No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑Yes ❑No

Are you under stress? ❑Yes ❑No Do you like your smile? ❑Yes ❑No

Is there anything you would like to change about your smile? ❑Yes ❑No, if Yes what is it? _____

Are you happy with the color of your teeth? ❑Yes ❑No Interested in having whiter/brighter teeth? ❑Yes ❑No

Do your gums bleed? ❑Yes ❑No How many times a do you: floss/week? _____brush /day? _____

Do you have difficulties brushing your teeth? ❑Yes ❑No

Are your teeth sensitive to heat, cold or anything else? ❑Yes ❑No Have you lost any teeth? ❑Yes ❑No

Have you ever been in an accident that damaged your teeth? ❑Yes ❑No

Do you snore? ❑Yes ❑No Do you play sports? ❑Yes ❑No Do you have bad breath? ❑Yes ❑No

Do you use tobacco (smoke or chew)? ❑Yes ❑No Do you drink coffee or tea? ❑Yes ❑No

Have you ever had a serious/difficult problem with any previous dental work? ❑Yes ❑No

Have you ever had any unfavorable dental experiences? ❑Yes ❑No

When was your last dental cleaning? _____When was your last dental visit? _____

Why did you leave your previous dentist? _____ _____

How can we accommodate you better during your dental visit? _____ _____

Here at Alliance Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Zoom Tooth Whitening	Veneers/Lumineers	Invisalign
Traditional Orthodontics (Brackets)	Smile Makeover	Bonding
Sealants	Crown and Bridge	Implant Crowns
Partials/Dentures	Night/Sport Guards	Botox

Signature: _____ Date: _____/_____/_____

Alliance Dental
Dr. Spaska Malaric, DMD
1400 Royal Palm Square Blvd, Suite 101
Fort Myers, FL 33919
Tel 239-939-2433, Fax 239-939-5510
www.alliance.dental

Patient Consent Form

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:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining my payment from third party payers (e.g. my insurance company)
- 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 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 restrictions on how my protected health care information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with these restrictions.

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.

Date _____/_____/_____

Patient Name: _____

Relationship to Patient: _____

Signature: _____