MEDPLEX DENTAL
Holistic Dentistry

PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

SS# _____ EMAIL _____

ADDRESS _____
STREET APT# CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME # WORK#

PLACE OF EMPLOYMENT _____ ADDRESS _____

IF FULLTIME STUDENT, SCHOOL NAME _____-_____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

PERSON TO CONTACT IN CASE OF EMERGENCY

Has any member of your family ever been treated in our office? ☐ YES ☐ NO

NAME _____
ADDRESS _____

CITY/STATE/ZIP _____
TELELPHONE # _____

DENTAL AND MEDICAL HTORIES – UPDATES

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: EXAMINATION EMERGENCY CONSULTATION

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe _____ YES NO
Do you have dental examinations on a routine basis? Last visit _____ YES NO
Do you think you have active decay or gum disease? _____ YES NO
Do you brush and floss on a routine basis? Discuss _____ YES NO
Do your gums ever bleed? Discuss _____ YES NO
Do you like your smile? Why? _____ YES NO
Does food catch between your teeth? Any loose teeth? _____ YES NO
Do you want to keep your remaining teeth? _____ YES NO
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ YES NO
Have your past experiences in a dental office always been positive? _____ YES NO
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ YES NO

Name of the previous dentist (optional): _____
Date of the last full mouth X-rays (16 small films or panoramic): _____

MEDICAL HISTORY Please Circle

Are you under a physician's care now? Why? _____ Phone # _____ YES NO
Have you ever been hospitalized or had a major operation? Discuss _____ YES NO
Have you ever had a serious injury to your head or neck? Discuss _____ YES NO
Are you taking any medications, pills or drugs? What? _____ YES NO
Are you on a special diet? Discuss _____ YES NO
Are you allergic to any medications or substances? Please check box below:
☐Aspirin ☐ Penicillin ☐Codeine ☐ Acrylic ☐ Metal ☐Latex ☐ Rubber ☐Other _____

WOMEN (Please check): ☐Pregnant/Trying to get pregnant ☐Nursing ☐ Taking oral contraceptives

Discuss_____

Do you now have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

☐ Heart Trouble/Disease	☐ Bruise Easily	☐ Emphysema	☐ Yellow Jaundice	☐ Cold Sores
☐ Heart Murmur*	☐ Anemia	☐ Tuberculosis	☐ Kidney Problems	☐ Fever Blisters
☐ Irregular Heartbeat	☐ Excessive bleeding	☐ Cancer	☐ Renal Dialysis	☐ Herpes
☐ Angina/Chest Pain	☐ Sickle Cell Disease	☐ X-Ray Treatments *(Radiation)*	☐ Thyroid Disease	☐ Stroke
☐ Heart Attack/Failure	☐ Hemophilia *(Bleeding Problem)*	☐ Chemotherapy	☐ Parathyroid Disease	☐ Convulsions
☐ Congenital Heart Disorder	☐ Leukemia	☐ Stomach/Intestinal Disease	☐ Arthritis/Gout	☐ Epilepsy or Seizures
☐ Mitral Valve Prolapse*	☐ Recent Blood Transfusion	☐ Ulcers	☐ Rheumatism	☐ Fainting of Dizziness
☐ Scarlet Fever	☐ Swelling of Limbs	☐ Recent Weight Loss	☐ Pain in Jaw Joints	☐ Glaucoma
☐ Rheumatic Fever*	☐ Lung Disease	☐ Frequent Diarrhea	☐ Cortisone Medicine	☐ Tumors or Growths
☐ Artificial Heart Valve*	☐ Breathing Problem	☐ Diabetes	☐ Artificial Joint*	☐ Nervousness
☐ Heart Pacemaker*	☐ Shortness of Breath	☐ Excessive Thirst	☐ Venereal Disease	☐ Psychiatric Care
☐ Heart Surgery*	☐ Frequent Cough	☐ Hypoglycemia	☐ AIDS	☐ Alzheimer's Disease
☐ High Blood Pressure	☐ Hay Fever	☐ Liver Disease	☐ HIV Positive	☐ Allergies (Medicines)
☐ Low Blood Pressure	☐ Sinus Trouble	☐ Hepatitis A (Infectious)	☐ Genital Herpes	☐ Allergies (Pollen/Dust)
☐ Blood Disease	☐ Asthma	☐ Hepatitis B or C	☐ Drug Addiction	☐ Hives or Rash

Have you ever had any other serious illness not checked above? Discuss _____

Do you wish to talk to the dentist privately about any problem? _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ DATE _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings: _____

_____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
___	_____	NONE	_____	___	Dr. _____
___	_____	NONE	_____	___	Dr. _____
___	_____	NONE	_____	___	Dr. _____
___	_____	NONE	_____	___	Dr. _____
___	_____	NONE	_____	___	Dr. _____

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MEDPLEX DENTAL, INC.

7350 SANDLAKE COMMONS BLVD, SUITE 1121, ORLANDO, FL 32819
TELEPHONE: 407-351-2245 • FAX: 407-351-0556

CONSENT TO TAKE X-RAYS

I, _____, hereby authorize to take my digital X-rays.

_____ _____

Patient's Signature Date Doctor's Signature Date

_____

Witness's Signature Date

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FINANCIAL OPTIONS FOR MEDPLEX DENTAL INC.

This office is committed to providing you the best possible dental care in the most inexpensive way that we possibly can. Dr. Castellini does not see patients from Health Maintenance Organizations (HMO) as we do not want to be forced to see huge amounts of patients daily so that we can treat them with the time and care that we feel is so important. Your clear understanding of our financial options is IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP.

- We offer a one-year interest free payment plan.
- 10% courtesy discount for payment in full.
- We accept cash, Visa, MasterCard, Discover, Nevus and American Express
- We have eliminated billing to keep costs down for you. Any unpaid balance after insurance payment will require a pre-authorization financial agreement.

REGARDING INSURANCE

We are happy to process your insurance claim. We will let you know in advance the fee or the eliminated copayment so that you will be prepared; we will explain how your plan works and how you can use the plan at our office. We are happy to provide this service at no cost to you. To avoid misunderstandings and to help you make informed decisions, we would like to provide you with a brochure that will answer some of your questions about dental fees and insurance.

REGARDING APPOINTMENT RESERVATION

In order to offer the most inexpensive dentistry possible, our options regarding appointment time reservation is as follows:

- THERE IS A MINIMUM OF 24 HOURS TO BE ABLE TO RESERVE AN APPOINTMENT WITH PRE-AUTHORIZATION FINANCIAL AGREEMENT.
- WHEN AN APOINTMENT IS MADE, IT IS CONSIDERED A FIRM AGREEMENT.
- ANY BROKEN APPOINTMENT WILL BE CHARGED $35.00 (UNLESS IT IS CANCELED WITHIN 24 HOURS IN ADVANCE).

REGARDING X-RAYS COPIES

We will not accept insurance on your first visit. However, we will help you fill out your insurance claim at no cost to you. On subsequent visits, we may accept your insurance if you obtain approval from our office staff prior to the date of service.

If you are not an established patient of record and come in for a dental emergency, you will be responsible for the payment. We will help you complete a claim form at no cost to you so that you can be reimbursed by your insurance company. Types of payments accepted are listed above.

SIGNATURE _____ DATE _____

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ORLANDO, FL 32819

STATEMENT OF UNDERSTANDING

I agree that the determination of professional services to be rendered by my Dentist and the fees compensate him/her services are a matter concerning my Dentist and me. I understand that I have the primary duty and obligation to pay the Dentist for his/her services. Notwithstanding any contract I may have any third party (be insurance company, employer, union on, government or the like).

I will not permit any third party to determine what medical services I need or what fees the Dentist should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our Dentist-Patient relationship and the decision related the dental care and fees.

Patient Signature _____ DATE _____

Doctor Signature _____ DATE _____