PATIENT INFORMATION
AND
MEDICAL HISTORY

EDWARD B. SEVETZ, JR., D.M.D.
Suite No.7, Medical Arts Center
2140 Kingsley Avenue
Orange Park, Florida 32073

Date _____ Who may we thank for referring you? _____

Patient _____ Birthdate _____ Age _____

Address _____
STREET CITY STATE ZIP

Phone _____ Sex ____ SS# ____/____/____ Email _____

Where and when are the best times to reach you? _____

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Child ☐

Patient's Employer _____
COMPANY NAME

_____
ADDRESS CITY, STATE, ZIP PHONE

Name of Spouse _____

Spouse's Employer _____
COMPANY NAME

_____
ADDRESS CITY, STATE, ZIP PHONE

Name of Responsible Party _____

Responsible Party's Address (if different from above)

_____
ADDRESS CITY, STATE, ZIP PHONE

Responsible Party's Employer (if different from above) _____
COMPANY NAME

_____
ADDRESS CITY, STATE, ZIP PHONE

INSURANCE:	MEDICAL	DENTAL
Name of Insurance Company		
Name of Insured Party		
S.S.# / D.O.B. of Insured	/	/
Group Number		

PAYMENT is expected at the time services are rendered. How do you plan to pay for today's visit? (Circle one)

Cash Check Visa / Discover / Mastercard

FOR OUR RECORDS, please present your insurance card and driver's license.

(Continued on back, please)

Family Doctor _____ Dentist's Name _____

1. Are you being treated or have you been treated for any of the following conditions? (PLEASE **CIRCLE** EITHER YES OR NO)

Yes No Unusual Prolonged Bleeding from Cuts, Previous Tooth Extractions
Yes No Heart Conditions
Yes No Pain or Pressure in the Chest
Yes No Rheumatic Fever
Yes No Mitral Valve Prolapse
Yes No High Blood Pressure
Yes No Kidney or Bladder Disease
Yes No Arthritis
Yes No Asthma or Other Breathing Problems
Yes No Tuberculosis
Yes No Stomach, Liver or Intestinal Trouble
Yes No Diabetes
Yes No Ear, Eye, Nose or Throat Trouble
Yes No Sinus Problem
Yes No Epilepsy or Fits / Fainting Spells
Yes No Severe or Frequent Headaches
Yes No Thyroid Disease
Yes No Cancer

Yes No Mental Disorder
Yes No Drug / Alcohol Abuse
Yes No Sickle Cell Disease
Yes No Hepatitis
Yes No Venereal Disease / Herpes
Yes No Previous Problems with General Anesthesia
Yes No Tested HIV+
Yes No Glaucoma
Yes No Artifical Joints, Valves or Shunts

Please List Any Other Medical Conditions (Past or Present) Before We Initiate Treatment:

_____
_____
_____
_____
_____

2. Yes No Are you taking any prescription medication now or within the last year?
   List medications: _____
   For what condition? _____
3. Yes No Are you taking any **non**-prescription medication, **including aspirin**, now or within the last month?
   List medications: _____
   For what condition? _____
4. Yes No Any allergies to medicines? Please list _____
5. Yes No Are you under the care of a physician now or within the last 6 months?
   For what? _____
   Date of last physical _____
6. Yes No Have you been hospitalized in the last 5 years?
   When and for what condition? _____
7. Yes No Do you now or have you ever experienced jaw joint (TMJ) pain, popping, clicking or locking?
8. Yes No Do you smoke cigarettes or use tobacco in any other form?
   How much on an average day? _____
9. Yes No Are you pregnant? _____ months

I UNDERSTAND THAT THE ABOVE MEDICAL HISTORY INFORMATION IS A VITAL PART OF MY EVALUATION FOR TREATMENT. I CERTIFY THAT THIS INFORMATION IS CORRECT AND COMPLETE AND NO INFORMATION HAS BEEN WITHHELD FOR ANY REASON. *If I have any changes in my health or medications I will notify Dr. Sevetz at the next appointment* ***without fail.***

I give permission to have appropriate x-rays and any necessary photographs taken to diagnose, record and plan my treatment, and for teaching purposes (providing my identity is not revealed). I acknowledge that I am ultimately responsible for payment of services rendered to the patient, and any legal fees included in the collection thereof.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent or Guardian (If patient is under 18 Years of age) Date

_____ _____
Signature of Doctor **Date**

FINANCIAL RESPONSIBILITY AGREEMENT

We are committed to providing you with the best possible care we can. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, Mastercard, Visa or Discover.

I ACKNOWLEDGE MY FULL RESPONSIBILITY AND AGREE TO PAY FOR ANY AND ALL COLLECTION FEES THAT ARE ADDED TO BALANCES OLDER THAN 30 DAYS AND FOR ANY RETURNED CHECKS.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. However, please understand that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

If we are a participating provider of your insurance, it is our policy that you be responsible for payment on the first visit and we will file for reimbursement to you. Any subsequent treatment will automatically be filed for you.

If we are not a participating provider of your insurance, we will file for reimbursement as a courtesy to you, but payment must be made prior to the services. If you prefer, in advance of any elective surgical procedure, we can request that your insurance carrier give a written estimate on what they will pay towards the proposed surgery. Please understand that if your insurance company does not pay 100% for the services rendered, you are solely responsible for the balance.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to assist you.

A copy of this agreement will be as valid as the original.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS DATE

HIPAA Release Form

Patient Name: _____ Data of Birth: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:

- ☐ my home
- ☐ my work
- ☐ my cell number: _____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ do not leave a message

_____ _____

Signature Date