Asbury Family Dentistry

office@asburyfamilydentistry.com

Asbury Family Dentistry | 91 Branscomb Rd Ste 7 • Green Cove, FL 32043 (904)284-6688

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ Last ____________ First ____ M ____________ Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other

Birth Date: __________ **Prev. Visit:** __________ **Email Address:** ____________________

Phone: __________ Home __________ Mobile __________ Work ______ Ext **Best time to call:** ____________

Address: ____________________ Address 1 ____________________ Address 2

____________________ City ______ State ______ Zip Code

Has your insurance changed since last visit? ○ Yes ○ No

Name of Insured: ____________________ Last ____________________ First ____ M

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ____

Insurance ID# ____________________

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Allergies	☐ Allergy - Asprin	☐ Allergy - Codeine	☐ Allergy- Benadryl
☐ Allergy- Sudafed	☐ Allergy-Adhesive	☐ Allergy-Bactrim	☐ Allergy-E-Mycin
☐ Allergy-Ibuprofen	☐ Allergy-Keflex	☐ Allergy-Laxtex	☐ Allergy-Levaquin
☐ Allergy-Naproxen	☐ Allergy-Nickel Metal	☐ Allergy-Penicillin	☐ Allergy-Red Dye
☐ Allergy-Shell Fish	☐ Allergy-Sulfa	☐ Allergy-Tylenol	☐ Allery- Prednisone
☐ Alzheimers/ Dementia	☐ Anemia	☐ Arthritis	☐ Artificial Heart Val
☐ Artificial Joints	☐ Asthma	☐ Autism	☐ Bleeding Abnormally
☐ Blood Disease	☐ Blood Thinners	☐ Cancer	☐ Cerebral Palsy
☐ Chemical Dependency	☐ Chemotherapy	☐ Circulatory Problems	☐ Cough, Persistent
☐ Diabetes	☐ Epilepsy	☐ Fainting	☐ Glaucoma
☐ HIV	☐ Heart Disease	☐ Heart Problems	☐ Hepatitis
☐ High Blood Pressure	☐ Hypoglycemia	☐ Immune Deficiency	☐ Kidney Disease
☐ Legally deaf	☐ Liver Disease	☐ Low Blood Pressure	☐ MS
☐ MVP	☐ Osteoporosis Shots	☐ Pacemaker	☐ Pain Mangement
☐ Parkinsons Disease	☐ Pregnancy	☐ Psychiatric TX	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Shingles	☐ Sickle Cell Anemia
☐ Sinus Problems	☐ Sjorgens	☐ Sleep Apnea	☐ Stents
☐ Stroke	☐ Substance Abuse	☐ Thyroid Problem	☐ Tramatic Brain Injur
☐ Tuberculosis	☐ Ulcers	☐ Vertigo	

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

____

____

Allergies not listed:

____

____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: ○ Yes ○ No

Reason for Pre-Med and Date

____

____

Name of your Physician and Phone Number:

____

____

Preferred Pharmacy, Location and Phone Number:

____

____

Name and Number of Emergency Contact

____

____

Please list authorized person/s with whom we may discuss your Protected Health Information in addition to custodial parents and/or legal guardians. If no one enter none:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below:

O Yes O No

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

Signature (non digital form) or Name of patient,parent or guardian completing this form:

Relationship to patient:

Date:

Response Date: ___________

Asbury Family Dentistry

office@asburyfamilydentistry.com

Asbury Family Dentistry | 91 Branscomb Rd Ste 7 • Green Cove, FL 32043 (904)284-6688

******IMPORTANT******

We require a 24 hour confirmation for all appointments. On any appointment 90 minutes or longer we require 48 hours notice if you need to cancel or reschedule. WE REQUIRE ALL APPOINTMENTS TO BE CONFIRMED. If we do not receive a confirmation for your appointment we will consider you are not coming to your appointment and will fill that spot. We do have a answering service that is available for you to leave a message if our office is closed or we can not be reached.

To cut down on our no-show and last-minute cancelations we have implemented DEPOSITS for restorative and deep cleaning appointments. $50 per ½ hour fee is due when scheduling an appointment.

If you NO SHOW or CANCEL with less than 24-hour notice for a cleaning appointment, we will REQUIRED to pay a $25 deposit to reschedule.

We REQUIRE a 24-hour notice to cancel or reschedule to avoid losing your deposit. A new deposit will be required to reschedule an appointment.

Our NO SHOW or CANCELATION fee is $50 and must be paid to reschedule an appointment. Please CONFIRM your appointments to potentially avoid losing your reserved time.

There is a 3% surcharge for CREDIT transactions. No charge for DEBIT or CASH. WE DO NOT ACCEPT CHECKS.

After 2 missed appointments, you will be REQUIRED to pay your visit in full to reschedule.
After 3 missed appointments, you will be dismissed from the practice.

Signature (non digital form) or Name of patient,parent or guardian completing this form: *

____

Relationship to patient: *

____

Date: * __________

Response Date: ____________