JACQUELINE NELSON MANGATAL, DDS, PA
4330 W BROWARD BLVD. SUITE M
PLANTATION, FL 33317
(954)7913884 Phone
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PATIENT INFORMATION:

First Name: ________________________ Last Name _____________________ Middle Initials ___________
Birth Date: _____________ SS#: __________________ Driver License #: ______________________________
Address: ___________________________ City, State, And Zip: _____________________________________
Home Phone: _________________ Cellular: ________________ Work Phone: ______________ Ext: ______
M___ F___ Married: ___Single: ___Divorced: ___ Widowed: ____ Minor: __Partnered for _____Years
Employer: ___________________________________Employer Phone: ______________________________
Employer Address: ____________________________ City, State, And Zip: ___________________________
Who May We Thank for Referring You: ____
Who to contact in case of an emergency: __________________________ Phone #: ___________________

RESPONSIBLE PARTY: (If someone other than the patient)

First Name: ____________________Last Name: ________________ Middle Initial: ____________________
Address: ________________________ City, State, And Zip: ____
Home Phone: _________________ Cellular: ________________ Work Phone: ______________ Ext: ______
Birth Date: _____________ SS#: __________________ Driver License #: ______________________________
Currently a patient in our office: Yes ________________________ No ______________________________
Employer: ___________________________________Employer Phone: ______________________________
Employer Address: ________________________ City, State, And Zip: ______________________________

INSURANCE INFORMATION:

Name of Insured: _________________________ Relationship to Patient: ____________________________
Insured Social Security #: ___________________ Insured Date Of Birth______________________________
Insurance Company: _____________________ Address: ____
City, State, Zip: ___________________________ Group #: ____
Deductible: ____________________ Max Annual Benefit: ____

DENTAL HISTORY:

Reason for today's visit _________________________Date of last dental care________________________
Former Dentist ____________________________ Date of last dental X-rays_________________________
Address ____________________________ City, State, Zip _______________________________________
Check if you have or had problems with any of the following:
Bad Breath ____ Clicking or Popping Jaw _____ Food Collecting between the teeth__________________
Bleeding Gums_____ Grinding teeth _____ Loose or Broken fillings _____ Periodontal treatment ______
Sensitivity to cold _____ Sensitivity to hot _______ Sensitivity to sweet _____________________)_____
Sensitivity when biting _________________________ Sores or growths in your mouth _______________
How often do you floss? __________ How often do you brush? __________________________________

TIME 10:43 AM

DATE 7/12/2011

MEDICAL HISTORY

PATIENT NAME ____________________ Birth Date ____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ 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 injury? ◯ Yes ◯ No If yes, please explain: ____________________
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________________
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________________
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ____________________

Do you have, or have you had, any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯ Yes	◯ No	Cortisone Medicine	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis A	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Hepatitis B or C	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Easily Winded	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No	Epilepsy or Seizures	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Excessive Bleeding	◯ Yes	◯ No	Hives or Rash	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Fainting Spells/Dizziness	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	Frequent Cough	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Frequent Diarrhea	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No	Stomach/Intestinal Disease	◯ Yes	◯ No
Breathing Problem	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Genital Herpes	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Hay Fever	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Cold Sores/Fever Blisters	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No	Parathyroid Disease	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Convulsions	◯ Yes	◯ No	Heart Trouble/Disease	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
									Yellow Jaundice	◯ Yes	◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ____________________

Comments: ____________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____________________ DATE ____________________

Dr. Jacqueline Nelson Mangatal and her staff are committed to helping the patients achieve and maintain healthy teeth and gums for life. The procedures we follow are in interest of achieving this for as many of our patients as possible.

Following your examination, the doctor will be giving you dental information that you may have or have not been aware of prior to your dental visits. Our office goal is to provide detailed dental information on your oral health in a timely and relaxed manner that allows an exchange of information between yourself and the doctor. This may necessitate one to two visits.

A professional cleaning performed by a dental hygienist or a dentist is a medical procedure, and must be prescribed by a qualified health care practitioner. In some cases, a different type of cleaning is what is needed for the health of the patient.

Because of this legally and ethically, an examination and x-rays, as required by the dentist and must be done before any type of cleaning can be stared. After an examination and x-ray has been done, the doctor will be able to see whether or not a cleaning is needed as the next step, or if a different procedure (which may include a more involved other type of cleaning) is required.

I have read the above statement; I have given the opportunity to ask any questions about the statement.

X ______________________________ X ______________________________
Please Sign Date

In the event that you need dental treatment, is there another person (e.g. spouse, parent, etc) who's involved in decision regarding your healthcare and/or your financial decision? Yes ____ NO ____

If yes, please give their names and relationship to you;

____

ACKOWLEGE RECEIPT OF NOTICE OF PRIVACY PRACTICES
Notice to patient:

We are required by HIPPAA to provide you with a copy of our privacy practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledge if you wish.

I acknowledge that I have received a copy of this office's notice of privacy practices.

X	X	X
Please print your name	Signature	Date

OFFICE USE ONLY:

We made every effort to obtain written acknowledge of receipt of our notice of privacy from this patient but it could not be obtained because.

- Patient refuse to sign
- Due to an emergency situation it was not possible to obtain an acknowledgement
- We weren't able to communicate with patient
- Other (please provide specific details)

  ____

X	X
Employee Signature	Date

WRITTEN FINANCIAL POLICY

Thank you for choosing Dr. Nelson dental office for your dental care. Our mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of dental care as easy and manageable as possible for our patients by offering several payment options.

PAYMENT OPTIONS:
You can choose from:

-Cash, Visa, MasterCard, American Express or Discovery Card, checks

-No Interest Payment Plans from Care Credit, Citi Health, Springstone

- Allows you to pay over time with NO INTEREST!
- Convenient, low monthly payment plans also available
- No annual fees or pre-payment penalties

PLEASE NOTE:

Dr. Nelson requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will be giving a refund accordingly.

For treatment plans requiring multiple appointments, alternative payment arrangement may be provided.

For patients with dental insurance we are happy to work with your carrier. The patient is responsible for any out of pocket expenses not covered by your insurance carrier prior to the beginning of the treatment.

A fee of $25 is charge for patients who miss or cancel more than one time in a calendar year without 48 hour notice or having confirmed their appointment either by telephone call or text messaging.

A fee of $25 is charge for duplicate x-rays upon request.

If you have any questions, please do not hesitate to ask. We are here to help you get the care you need to ensure healthy teeth and gums.

X	X
Print Name	Please Sign

Office Policy

A $25.00 fee will be charge for all appointments not cancelled 24 hours in advance.

Print Name_______________________

Sign________________ Date__________

We reserve the right to charge for appointment cancelled or broken without 24hrs advanced notice, if we receive telephone confirmation.