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Suite 201
Orlando, FL 32828
407-658-0103

ELITE DENTISTRY

Dr. MARK ASHY

Medical Alert For Office Use

Thank you for visiting Elite Dentistry. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL NICKNAME

Address _____
STREET

CITY STATE ZIP

Employer _____ E-Mail Address _____

Birth date _____ Driver's License # _____

Phone: Home (____) _____ Social Security # _____

Work (____) _____ May we contact you at work? Yes No

Mobile(____) _____ Female Male Marital Status _____

Emergency Name /Relationship: _____ Phone: _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

CITY STATE ZIP

Telephone (____) _____

Other Information

How did you hear about us? _____

What is the reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like most about your last dentist? _____

What did you like least about your last dentist? _____

Medical History and Information

Do you have or have you ever had?

- Arthritis
- Asthma
- Cancer
- Diabetes
- Epilepsy
- Glaucoma
- Heart Murmur
- Heart Problems
- Hepatitis
- High Blood Pressure
- HIV Positive
- Jaundice
- Kidney Problems
- Low Blood Pressure
- Rheumatic Fever
- Sexually Transmitted Diseases
- Stroke
- Tuberculosis
- Other _____

List any known drug allergies: _____

Do you Smoke? _____

Have you had any Joint Replacement Surgery? _____

Are you currently under the care of a physician?

- Yes No

Please explain: _____

Please list any medication you are currently taking:

Female Patients: Are you pregnant?

- Yes No

If yes, when is your due date? _____

Are you nursing? _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE

DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE

DATE