

Derek R. Fleitz, D.D.S., P.A.

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Thank you for selecting our practice for your dental care. We strive to insure that our patients receive the highest level of quality care and attention. To help us meet your dental healthcare needs, please complete this form in its entirety. If you have any questions or concerns or need any assistance in completing this form, do not hesitate to ask. We will be happy to help.

Patient Information (Confidential)

Please Print in Ink

Name _____ Date _____

Prefix First MI Last

Name you prefer to be called _____ Date of Birth _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Do you prefer to receive calls at: Home Work Either

Email Address _____

Are you: a Minor Married Single Divorced Widowed Separated

Employer _____ Occupation _____

(Parent' employer if a minor)

Business Address _____ City _____ State _____ Zip _____

Spouse's or Parent's Name _____ Daytime Phone # _____

If you are a student, name of school/college _____ City/State _____

Person to contact in case of emergency _____

Relationship to Patient _____ Daytime Phone # _____

How did you hear about us? (Please provide name) Friend's name _____ Family _____

Doctor referral _____ Mailing/Letter Newspaper Yellow Pages Other? _____

Responsible Party

Name of Person responsible for this account _____

Relationship to Patient _____ Home Phone # _____

Address _____ City _____ State _____ Zip _____

Name of Employer _____ Work Phone # _____

For your convenience we accept several forms of payment. Please circle the option you prefer:

Cash Personal Check Discover MasterCard VISA Care Credit Financing

Payment in full is expected at each appointment.

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Date of Birth _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone# _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Contract# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Deductible amount _____ How much have you used? _____ Max. annual benefit _____

Name _____ Date of Birth _____ Age _____

Dental History

Former Dentist _____ City/State _____

Reason for Today's Visit _____

Date of Last Dental Exam _____ Date of Last Dental X-rays _____ How often do you brush? _____ floss? _____

Please check any of the following conditions that apply to you: (check those that apply) _____ Dental Anxiety
____ Bad Breath _____ Loose teeth or broken fillings _____ Sensitivity to sweets _____ Gag Response
____ Bleeding gums _____ Periodontal treatment _____ Sensitivity when biting/chewing _____ Any removable appliance
____ Clicking or popping jaw _____ Sensitivity to cold _____ Sores or growths in your mouth _____ Food collection between teeth
____ Grinding teeth _____ Sensitivity to hot _____ Cold sores or Fever blisters _____ Difficulty "getting numb"

Have you ever had any difficulty with tooth extractions or excessive bleeding as a result? _____

Do you have any dental implants? _____

Medical History

Physician _____ Date of last visit _____

(Women) Are you/think you may be pregnant? __ Yes __ No Are you nursing? __ Yes __ No Taking birth control pills? __ Yes __ No

(Everyone) Please list all medications and supplements you are currently taking: _____

Check any of the following that you currently are taking OR have taken in the past:

____ Osteoporosis drugs (Fosamax, Actonel, Boniva, or other) _____ Cortisone drugs _____ Steroids _____ Blood Thinners _____ Anticoagulants
____ Aspirin _____ MAO Inhibitors _____ Sedatives _____ Tranquilizers _____ Anti Depressants _____ Medication before dental treatment

Do you have allergies to or have you had any reactions to any of the following: (check those that apply)

____ Local Anesthetics (e.g. Novocaine) _____ Penicillin/Amoxicillin _____ Clindamycin _____ Codeine _____ Sulfa Drugs _____ Latex Rubber
____ Aspirin _____ Sedatives (e.g. Valium) _____ Any Metals (e.g. nickel, mercury, etc.) _____ Other (please list) _____

Do you have a history of the following? (check those that apply)

____ AIDS _____ Diabetes _____ HIV Positive _____ Rheumatic Fever
____ Alzheimers _____ Epilepsy _____ Jaw Pain _____ Sinus Problems
____ Anemia _____ Excessive Bleeding _____ Kidney Disease _____ Skin Rash
____ Angina Pectoris _____ Fainting _____ Liver Disease _____ Stroke
____ Arthritis/Rheumatism _____ Glaucoma _____ Mitral Valve Prolapse _____ Thyroid Problems
____ Artificial Heart valves _____ Headaches _____ Nervous Problems _____ Tobacco Habit
____ Artificial Joints _____ Heart Murmur _____ Osteoporosis/Osteopenia _____ Tuberculosis
____ Asthma _____ Heart Problems _____ Parkinson's Disease _____ Ulcer
____ Blood Disease _____ Describe _____ Pacemaker _____ Venereal Disease
____ Cancer, Type _____ Hemophilia _____ Psychiatric Care _____ Other _____
____ Chemical Dependency _____ Hepatitis _____ Radiation Treatment
____ Chemotherapy _____ High Blood Pressure _____ Respiratory Disease

Authorization and Consent of Patient (by Parent or Guardian if Patient is a minor)

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, I will inform the doctor and his staff at the next appointment without fail. I authorize Dr. Fleitz and staff to take and record any photographs of me for records, teaching, research and publication purposes. I understand that in any publication use, my name will not be identified. I authorize Dr. Fleitz and staff to take any x-rays necessary for the detection and diagnosis of oral diseases and to administer local anesthetics and medically indicated drugs as necessary for treatment. I authorize Dr. Fleitz to release any information including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Fleitz benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. I understand that payment in full is expected at each appointment. Accounts more than 60 days past due are subject to a service charge of 1.5% per month (18% per annum) on the unpaid balance.

X _____
Signature of Patient (Parent if patient is a minor) _____ Date _____

Doctor's Comments: _____

Doctor's Signature Date _____

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Cosmetic, Implant & General Dentistry

Name: _____

Smile Evaluation

*Please answer a few questions to help us meet your needs
and address your concerns. Thank You!*

How would you rate your smile? (not good) 1 2 3 4 5 6 7 8 9 10 (great)

Are you happy with the color of your teeth? ___yes ___no ___not sure

Are you happy with the shape of your teeth? ___yes ___no ___not sure

Do you feel that your teeth are crooked? ___yes ___no ___not sure

If you could change anything about your smile, what would it be?

Questions for DENTURE and PARTIAL wearers:

How long have you worn dentures/partials? _____

How many sets of partials/dentures have you had throughout your life? _____

Please circle Yes or No:

Yes No Are your dentures/partials comfortable?

Yes No Do you use denture adhesives or pastes to help secure your dentures/partials?

Yes No Do you avoid eating certain foods?

Yes No Does your denture/partial move, slip or feel loose when you talk, eat, laugh, yawn or sneeze?

Yes No Do you feel your dentures/partials have decreased the flavor of foods you eat or reduced your thermal sensations?

Yes No Do you have a hard time cleaning your dentures/partials or remaining teeth?

Yes No Do you leave your dentures/partials in at night?

Yes No Would you like to discuss a fixed alternative that you do not have to remove?

*Thank you for selecting our practice for your dental health care needs.
It is a great privilege to serve you!*

Map to Derek R. Fleitz, D.D.S.
2407 W. 11th Street
Panama City, FL 32401

We are located in the St. Andrews area of Panama City on W. 11th Street between Beck Ave. and Frankford Ave. Look for the green sign on our front lawn. Call us at 763-5309 if you have a problem finding us.

Our **parking** lot is located on Foster Ave. or you may park on 11th Street in front of the office.

This map is for your convenience. It is not drawn to scale.

