VERO BEACH
Art OF DENTISTRY
M. Johnson Hagood, DDS

Personal Identification-

Last Name: _____ First Name: _____ Middle: _____

Name you prefer to be called: _____ Title: ❑ Mr. ❑ Mrs. ❑ Miss. Other: _____

Street Address: _____ City: _____

State:_____ Zip: _____ Home Phone: (_____)_____ Year-Round Resident: ❑ Yes ❑ No

Work Phone: (_____)_____ Cell Phone: (_____)_____

I prefer to be contacted at my: ❑ Home number ❑ Work number ❑ Cell number Email:_____

May we text/email you about upcoming appointments: ❑ Yes ❑ No

Gender: ❑ Male ❑ Female Marital Status: ❑ Divorced ❑ Married ❑ Single ❑ Separated ❑ Widowed

Birth date:_____ Soc. Sec. #: (only if you have insurance)_____

Party Responsible for Payment: ❑ Self ❑ Spouse ❑ Parent ❑ Caregiver ❑ Other _____

Name of Responsible Party:_____ Signature: _____

Who referred you to our office? _____

Insurance Information

Dental Insurance Company (if applicable): _____Group/ID #:_____

Address: _____Phone: (_____)_____

Subscriber: ❑ Self ❑ Spouse ❑ Parent ❑ Other Subscriber Name: _____ DOB:_____ SS#:_____

We are a fee for service practice. Payment is due at time of service unless other arrangements are made. We will provide all necessary dental forms needed to help you obtain reimbursement from your dental insurance company.

Employment Status

Employer (School if student): _____Title (Major if student):_____

Employer/School Address: _____

Emergency Contact Information

Emergency Contact Name:_____ Relationship: _____

Emergency Contact Phone Number: (_____)_____

Medical Information

Primary Care Physician's Name: _____ Phone: (_____)_____

Are you under a physician's care now? ❑ Yes ❑ No Reason:_____

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No Reason: _____

Please list any medications you are currently taking:

Medication	Reason	Medication	Reason

Do you use tobacco? ❑ Yes ❑ No Type: _____ Are you currently pregnant? ❑ Yes ❑ No

Do you have any known allergies? ❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Latex ❑ Sulfa ❑ Other_____

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

❑ AIDS/HIV Positive	❑ Cold Sores/Fever Blisters	❑ Glaucoma	❑ Herpes	❑ Radiation Treatment
❑ Alzheimer's Disease	❑ Congenital Heart Disorder	❑ Hay Fever	❑ High Blood Pressure	❑ Rheumatic Fever
❑ Anemia	❑ Diabetes	❑ Heart Attack/Failure	❑ Hypoglycemia	❑ Scarlet Fever
❑ Angina	❑ Emphysema	❑ Heart Murmur	❑ Irregular Heartbeat	❑ Sinus Trouble
❑ Artificial Heart Valve	❑ Epilepsy/Seizures	❑ Heart Pacemaker	❑ Kidney Problems	❑ Tuberculosis
❑ Artificial Joint	❑ Excessive Bleeding	❑ Heart Trouble/Disease	❑ Liver Disease	❑ Yellow Jaundice
❑ Cancer	❑ Fainting Spells	❑ Hepatitis A	❑ Mitral Valve Prolapse	❑ Hepatitis C
❑ Chemotherapy	❑ Frequent Headaches	❑ Hepatitis B	❑ Pain in Jaw Joints	❑ Sleep Apnea

Have you had any serious illness not listed above? _____

Do you require a premedication prior to dental appointments: ❑ Yes ❑ No Reason: _____

Prescribing Doctor: _____ Phone: (_____)_____

Type prescribed: _____Dosage: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

Do you see another dentist for cleanings? Dentist: _____ Frequency: _____

Patient Signature: _____ Date: _____

Appointment Change and Cancellation Policy

Appointments are considered confirmed when they are made. Our office requires two business days notice for appointment change requests. This includes requests for changes in time, date, treatment, provider, or appointment cancellation. Please note that should you leave a request for change on our voicemail when the office is closed, we will consider the request to have been made on the following business day.

Should you fail to give the required two business days notice for appointment changes, you will be charged a fee. This fee could be up to and including the full fee for the appointment you changed, cancelled, or missed.

I have read and understand the Appointment Change and Cancellation Policy.

_____ _____

Sign Date

M. Johnson Hagood, DDS, PA 2155 Ponce De Leon Circle Vero Beach, FL 32960 Phone: (772) 567-2237 Fax: (772) 567-1052 www.verobeachartofdentistry.com

M. Johnson Hagood, DDS
Informed Consent and Treatment Confirmation

Patient's Name: _____ Date _____

To my knowledge I have given an accurate report of my health history. Any prior allergic or unusual reactions, gum or skin reactions, abnormal bleeding and any other conditions related to my health are included.

I have been informed and understand that occasionally there are complications from treatment and local anesthesia. Complications can include but are not limited to: pain, swelling, sensitivity, gum discoloration, bruising, infection, drug/anesthetic reactions and side effects, damage to adjacent teeth or fillings, post-treatment bleeding, failure of the dental treatment procedure necessitating additional treatment, and complications during treatment necessitating referral to a specialist.

I understand that photos, radiographs, and other records may be made during the course of my examination, treatment and follow-up care. I give my permission for such items to be used for purposes of education, research, or publication in professional journals or websites. I understand my identity will not be revealed (by name). Please indicate if no full facial photos may be used during educational programs by checking here. ☐

After an oral exam performed by Dr. Hagood and with full understanding after discussion of all aspects of my dental treatment including potential modifications, I approve treatment as outlined by the doctor or his associates. I certify that I have read and understand all of this INFORMED CONSENT which outlines the general treatment considerations as well as the potential problems and complications of Restorative/Prosthodontic treatment. I understand that potential complications and problems may include, but are not limited, to those described in this document. I have been given the opportunity to ask questions about the proposed treatment and associated risks, as well as the potential consequences should I elect to postpone or refuse to implement care. I will be given an estimate and explanation of all fees associated with my treatment before treatment begins. I understand that conditions may occur during and following treatment that warrant additional or alternative care.

Signed _____ Date _____

Relationship if patient is a minor:_____

Witness _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I have reviewed this office's Notice of Privacy Practices which describes how my health information may be used or disclosed.
*A copy is available upon request.

_____ _____ _____
Print Name Signature Date

May we confirmed or leave messages concerning your appointments / treatment:
At home_____ At work_____ On your cell_____

Is there anyone with whom you would allow us to share your personal information or leave messages?
Who: _____
Relationship: _____

For office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (specify) _____