



Welcome to
Raffaella Armstrong D.M.D.

Patient Information

Today's Date: _____

Name: _____ Birth date: _____

Age _____ SS# _____ Birthplace _____

Address: _____ City: _____ Zip _____

Cell Phone: _____ Home Phone: _____

Work # _____ E-mail: _____

Occupation _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone: _____

Reason for today visit? _____

Insurance Information

Name of Insured _____ Relationship to patient _____

Birthdate _____ SS# _____

Name of Employer _____ Work # _____

Insurance Company _____ Group # _____

Broken appointments policy

A fee of \$30 will be charged for cancelled appt, without 24 hour notice.

Please sign X _____

I have read the Notice of Privacy Practices.

Please sign X _____

Patient Medical History

Are you allergic to or had any reaction to the following?

Local Anesthetics (e.g. Novocaine) Yes [] No []

Penicillin or any other Antibiotic Yes [] No []

Sulfa Drugs Yes [] No []

Barbiturates Yes [] No []

Sedatives Yes [] No []

Iodine Yes [] No []

Aspirin Yes [] No []

Any Metals (nickel, metal, etc.) Yes [] No []

Latex Rubber Yes [] No [] .

Are you under medical treatment? Yes [] No []

Have you ever been hospitalized Yes [] No []

For any operation or serious illness?
If yes, explain _____

Are you taking any medication? Yes [] No []

If yes what medications _____

Do you use tobacco? Yes [] No []

Have you taken Fen- Phen/Redux? Yes [] No []

Do you use controlled substances? Yes [] No []

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

- High Blood Pressure	Yes [] No []	- Heart Disease	Yes [] No []	Stroke	Yes [] No []
- Heart Attack	Yes [] No []	- Cardiac Pacemaker	Yes [] No []	Hay Fever	Yes [] No []
- Rheumatic Fever	Yes [] No []	- Heart Murmur	Yes [] No []	Tuberculosis	Yes [] No []
- Seizures	Yes [] No []	- Angina	Yes [] No []	Radiation	Yes [] No []
- Asthma	Yes [] No []	- Anemia	Yes [] No []	Glaucoma	Yes [] No []
- Low Blood Pressure	Yes [] No []	- Emphysema	Yes [] No []	Recent Weight Loss	Yes [] No []
- Epilepsy/ Convulsion	Yes [] No []	- Cancer	Yes [] No []	Liver Disease	Yes [] No []
- Leukemia	Yes [] No []	- Arthritis	Yes [] No []	Heart Trouble	Yes [] No []
- Diabetes	Yes [] No []	- Joint Replacement	Yes [] No []	Respiratory Problem	Yes [] No []
- Kidney Disease	Yes [] No []	- Jaundice/ Hepatitis	Yes [] No []	Mitral Valve Prolapse	Yes [] No []
- Aids or HIV	Yes [] No []	- Sexual disease	Yes [] No []	Other	Yes [] No []
- Thyroid Problem	Yes [] No []	- Chest Pain	Yes [] No []		

For females only: Are you pregnant? Yes [] No [] Due date _____ Are you nursing? Yes [] No []

Are you taking birth control pills? Yes [] No []

Are you taking any bisphosphonate medication (i.e. Zometa, Aredia) Yes [] No []

Patient Dental History

Former Dentist _____ Date of last exam _____ Date of last dental x-rays _____

1. Do your gums bleed while brushing or flossing? Yes [] No []

2. Are your teeth sensitive to hot or cold liquids? Yes [] No []

3. Do you feel any pain in your mouth? Yes [] No []

4. Do you have any sores or lumps in mouth? Yes [] No []

5. Have you experienced any of the following problems in your jaw?

Clicking	yes [] No []	6. Do you have frequent headaches? Yes [] No []
Pain	Yes [] No []	7. Do you grind your teeth? Yes [] No []
Difficulty opening or closing	Yes [] No []	8. Do you bite your lips or cheeks? Yes [] No []
Difficulty in chewing	Yes [] No []	9. Have you had difficult extractions? Yes [] No []
		10. Have you had prolonged bleeding? Yes [] No []
		11. Have you had ortho. treatment? Yes [] No []
		12. Do you wear dentures or partials? Yes [] No []
		13. Do you like your smile? Yes [] No []
		14. Have you'd head, neck or jaw injuries? Yes [] No []

Authorization and Release

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. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____ Date _____ X _____ Date _____

Signature of patient

Doctor's Signature

Assignment and Instruction for Direct Payment to Doctor

Patient: _____
Employer: _____
Claim Group: _____
SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Raffaella Armstrong D.M.D
150 SE 2nd Ave Ste #604
Miami, FL 33131

OR

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct the Insurance Company to make out the check to me and mail it as follows:

C/O Raffaella Armstrong, D.M.D.
To the Same as above

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall I be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

X

Signature of Policyholder

Date

Simple Agreement Form

Patient authorizes the Doctor to deposit checks received on Patient's account when made out to the Patient.

X

Signature of Policyholder

Date