# MICHAEL A. PAWLUS D.D.S., M.S.

WELCOME TO OUR OFFICE. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments or fees, please feel free to ask. The requested information will help us to serve you better and is associated with the proper management of your oral health.

Your answers will be considered confidential.

Date: ____________________ Referred By: ____________________________

Name: ____________________ ____________ ________ ____________________ ____ Dr. Mr. Mrs. Ms.
First Name Preferred Name Middle Initial Last Name

Residence: ________________________________________________________________
Street Address

______________________________ ______________ ____________________
City State Zip

________________ ________________ ________________ ________________
Residence Phone 2nd Residence Phone Work Phone Cell Phone

2nd Residence: ____________________________________________________________
Street Address

______________________________ ______________ ____________________
City State Zip

Sex: _____ M _____ F Marital Status: _____ Divorced _____ Married _____ Single _____ Widowed

Email Address: ____________________________________________________________

Social Security: ______________________________ Date of Birth: ____________________ Age: ______

Employer: ________________________________________________________________

In Case of Emergency Contact: ______________________________________________

Relationship: ____________________________________________ Phone: ____________________

1901 FLOYD STREET • SUITE 303 • SARASOTA, FLORIDA 34239
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MICHAEL A. PAWLUS D.D.S., M.S.

# DENTAL INSURANCE

**INSURANCE: With documented evidence of coverage, i.e. an insurance card, this office will submit claims for the insured party. The amount of reimbursement is determined by the insurance carrier. We do not accept responsibility for collecting on an insurance claim or for negotiating a settlement on a disputed claim. Also please note that Insurance is not accepted in place of payment unless we have conformation in writing from your insurance company that you do indeed have coverage for the procedures being performed. Patients are responsible for any balance on their account not covered or paid by their insurance. It is not our policy to contact insurance carriers to establish why they have not paid or why they paid less than originally indicated. We will submit the necessary claims for you as a courtesy on the date of service however it is the patient's responsibility to follow up or track the outstanding claim.**

**DENTAL INSURANCE:**

Name of Insurance Co. ____________________ Phone # ______________

Address _____________________ City/State/Zip ______________________

Name of Insured Party _______________________ Group# ____________

S.S.# _______________________ D.O.B. ______________________________

Insured's Employer _______________________________________________

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# FEES & PAYMENTS

**Payment is due on the date services are rendered unless previous arrangements have been made in writing. For your convenience we accept: VISA, Mastercard, Discover and American Express as well as cash or check.**

****A $25.00 processing fee will be charged for returned checks**

**I understand that there will be a finance charge of 3% per month on any outstanding balances after 30 days. I also understand that any balance left over 30 days may be turned over to our collection company and I agree to pay all reasonable costs incurred for this collection including interest, collection agency costs and/or attorney fees.**

**I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. If payment has not been received from my insurance company within 30 days of services rendered, I understand that I am responsible for all charges and that I will be reimbursed when payment is received.**

**I have read and understand the financial/payment policies, agree to the terms and accept full responsibility for all charges for services rendered.**

**Please Note – Dr. Pawlus is NOT a Medicare provider.**

**______________________ ______________________ _____________**
**(Print Name) (Signature) (Date)**

**If other than patient, indicate relationship ________________________**

# Medical Information

1. **ALLERGIES -** Please circle if you have had <u>any</u> adverse reaction to:

| Penicillin | Sedatives | Tranquilizers | Aspirin | Iodine | Local Anesthetics |
|---|---|---|---|---|---|
| Barbiturates | Codeine | Antibiotics | Sulfa Drugs | Muscle Relaxants | Other: ____________ |

   If Yes, Describe: ______________________________________________

2. Please list your doctors:

   Family Physician: ______________________ Phone: ______________________

   Other Specialists: ______________________ Phone: ______________________

3. List ANY drugs or medications you are presently taking. Please include over the counter prescriptions.

   ______________________________________________

   ______________________________________________

4. Preferred Pharmacy: ______________________ Phone: ______________________
5. Do you premedicate before you visit your dentist? ___ Y ___ N
6. Are you presently under the care of a physician? ___ Y ___ N

   If *Yes,* Name: ______________________ REASON ______________________

7. Have you been hospitalized in the past 2 years? ___ Y ___ N

   If *Yes,* Name: ______________________ REASON ______________________

8. Are you pregnant/nursing? *(If you become pregnant in the future, please be sure to inform us.)* ___ Y ___ N
9. Do you consume alcoholic beverages? ____________/day ___ Y ___ N
10. Are you taking aspirin? ____________/day ___ Y ___ N
11. Do you smoke or use tobacco products of any kind? ____________/day ___ Y ___ N

**<u>Have you ever been diagnosed and/or treated for:</u>**

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| Artificial/Damaged Heart Valves | ❒ Yes | ❒ No | Parkinson's Disease | ❒ Yes | ❒ No |
| Heart Murmur/Mitro Valve Prolapse | ❒ Yes | ❒ No | Fainting Spells/Seizures | ❒ Yes | ❒ No |
| Rheumatic Fever/Rheumatic Heart Disease | ❒ Yes | ❒ No | Epilepsy | ❒ Yes | ❒ No |
| Artificial Joints (Knee/Hip, etc.) | ❒ Yes | ❒ No | Respiratory Disease (Asthma, etc.) | ❒ Yes | ❒ No |
| Cardiovascular/Heart Disease | ❒ Yes | ❒ No | Emphysema/Bronchitis | ❒ Yes | ❒ No |
| Stroke/Cerebrovascular Disease | ❒ Yes | ❒ No | Gastrointestinal Disease | ❒ Yes | ❒ No |
| Chest Pain/Angina | ❒ Yes | ❒ No | Kidney Disease | ❒ Yes | ❒ No |
| High Blood Pressure | ❒ Yes | ❒ No | Diabetes | ❒ Yes | ❒ No |
| Anemia/Blood Disease | ❒ Yes | ❒ No | Thyroid Disease | ❒ Yes | ❒ No |
| Low Blood Pressure | ❒ Yes | ❒ No | Liver Disease | ❒ Yes | ❒ No |
| Arteriosclerosis | ❒ Yes | ❒ No | Hepatitis/Jaundice | ❒ Yes | ❒ No |
| Arthritis/Painful Joints | ❒ Yes | ❒ No | Glaucoma | ❒ Yes | ❒ No |
| Cancer/Tumor | ❒ Yes | ❒ No | Allergies | ❒ Yes | ❒ No |
| Clotting Problems | ❒ Yes | ❒ No | Sexually Transmitted Disease | ❒ Yes | ❒ No |
| Tuberculosis | ❒ Yes | ❒ No | HIV/AIDS | ❒ Yes | ❒ No |
| Sinus Problems | ❒ Yes | ❒ No | Osteoporosis | ❒ Yes | ❒ No |
| Pacemaker | ❒ Yes | ❒ No | Previous Use of Fosomax or Actonel | ❒ Yes | ❒ No |
| Neurological Problems | ❒ Yes | ❒ No | Are you currently taking a blood thinner? | ❒ Yes | ❒ No |

# Dental Health History

Primary dental complaint or reason for referral ____________________

____________________

Do you visit your dentist regularly? ❐ Yes ❐ No How often? ____________ Date teeth last cleaned ____________

Date of your last visit (or series of visits) ____________________

Have you ever had any problem associated with previous dental treatment? ❐ Yes ❐ No

Teeth brushed ____________ times a day. List floss or other aids used ____________________

On a scale of 1-5 (5 being the highest) what priority do you give your teeth? 1 2 3 4 5

Have you ever had ❐ Periodontal Treatment ❐ Endodontic Treatment ❐ Orthodontic Treatment ❐ Oral Surgery

**In respect to any previous dental treatment, have you:**

Ever fainted? ❐ Yes ❐ No

Had an undesirable reaction to local or general anesthesia? ❐ Yes ❐ No

Had abnormal bleeding? ❐ Yes ❐ No

Had slow healing? ❐ Yes ❐ No

Had any other complications during or following dental treatment? ❐ Yes ❐ No

If yes, describe: ____________________

Do your gums bleed on brushing or eating? ❐ Yes ❐ No

Have your teeth shifted or are they loose? ❐ Yes ❐ No

Are any of your teeth sensitive to heat, cold or pressure? ❐ Yes ❐ No

Do you grind your teeth or clench your jaws? ❐ Yes ❐ No

Do you have pain or clicking in the jaw joint around your ear? ❐ Yes ❐ No

Have your jaw muscles ever been sore? ❐ Yes ❐ No

Are there any sores or growths in your mouth? ❐ Yes ❐ No

Do any of your teeth ache? ❐ Yes ❐ No

Do you have any other special concern? If yes, please describe below. ❐ Yes ❐ No

I have read and understand the above questions to the best of my knowledge.

Print Name ____________________ Signature ____________________

If other than patient, indicate relationship ____________________

Signature of Dentist ____________________

Date: ____________

For office use only: Blood Pressure ____________