BP _____/_____

COLLINS DENTAL

Ticket Number: _____

Procedure you would like done today: (PLEASE CIRCLE ONE)

CLEANING FILLING EXTRACTION

Area of Concern: UR LR UL LL

How did you hear about the event?

Are you a Veteran? YES NO

Patient Information Date_____

Patient Name_____ D.O. B _____

Nickname_____ Male or Female Single / Married / Divorced / Widowed SS# _____

Your Address_____ City_____ St_____ Zip_____

Home#_____ Cell#_____ Work#_____

Email_____

Emergency Contact_____ Relationship_____ Phone#_____

Medical Health

Physician: _____ Phone#_____ Last Physical Exam_____/_____/____

General Health: Excellent___ Good___ Fair___ Poor___

Have you had any serious illness, operation, complication, been hospitalized in the past 5 years? No Yes, please explain:

_____

Are You Taking Medications? (If So What?) _____

_____

Are You Allergic To: Penicillin ___ Latex ___ Local Anesthetics ___ Codeine ___ Sulfa ___ None ___

Any Other Allergies? _____

Do You Have Any Dental Concerns? NO YES: _____

Women: Are You Pregnant or Think You May Be Pregnant? Yes No Trimester? 1 2 3 Nursing? Yes No

Indicate Which of The Following You Have Had or Have at Present. Circle Yes or No and Circle Options.

Abnormal Bleeding	YES	NO	Head Injuries	YES	NO	Nervous Disorders	YES	NO
AIDS/HIV Positive	YES	NO	Hearing Impaired	YES	NO	Osteoporosis	YES	NO
Alzheimer's/Dementia	YES	NO	Heart Disease	YES	NO	Bisphosphonates *IV/Oral?	YES	NO
Anemia	YES	NO	Heart Pacemaker	YES	NO	Parkinson's Disease	YES	NO
Arthritis/Rheumatoid	YES	NO	Heart Stent/Shunt	YES	NO	Prosthetic Joints*	YES	NO
Asthma	YES	NO	Heart Valve Replacement	YES	NO	*where/when?		
Blood Disease	YES	NO	Hepatitis*	YES	NO	Radiation Treatment	YES	NO
Blood Thinners	YES	NO	*Type: A, B, C, D, E, F, G?			Sinus Problems	YES	NO
Cancer	YES	NO	Herpes	YES	NO	Smoke/Chew Tobacco	YES	NO
Chemotherapy	YES	NO	High or Low Blood Pressure	YES	NO	Sleep Apnea/ CPAP	YES	NO
Convulsions/ Seizures	YES	NO	Infective Endocarditis	YES	NO	Steroid Use	YES	NO
Digestive Disease	YES	NO	Kidney Disease	YES	NO	Thyroid Disease	YES	NO
Diabetes Type 1 or 2?	YES	NO	Mitral Valve Prolapse	YES	NO	Ulcers	YES	NO
Excessive Bleeding	YES	NO	Multiple Sclerosis	YES	NO	Other:		
Epilepsy	YES	NO	Neck/Back Problems	YES	NO	Other:		

***For Parents of Minors: By Signing below, you are agreeing to be responsible Guardian for the minor's account and balances.**

Patient/Guardian Signature_____ **Date:** 11/06/2021

_____

Doctor Signature **Date**

5744 Canton Cove, Winter Springs, FL 32708
Phone: 407-699-9831 Fax: 407-699-9896
CollinsDentalCare.com

COLLINS DENTAL

Smiles from the Heart

Consent for Treatment and Photo

1. I hereby authorize the doctor or designated staff to take x-rays, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my limited dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all treatment mutually agreed upon by myself and the doctor to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medications, as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.
4. I give consent to the doctor's or designated staff's use and disclose of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment and health care options. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I understand that if my teeth can be cleaned for this event, only supra gingival cleaning will be performed, and the presence of periodontal disease requires further treatment which will not be performed at this event.
6. I understand that no prescriptions for narcotics will be written for this event.
7. I will hold Collins Dental Care, Orlando Oral and Maxillofacial Surgery, and participating doctors and staff in the "Smiles from the Heart" charitable event, held November 6, 2021 at 5744 Canton Cove, Winter Springs, FL harmless and indemnify them against all claims and actions out of their participation in this activity.
8. I hereby authorize Collins Dental, to publish photographs taken of me on November 6, 2021 and my name and likeness, for use in Collins Dental print, online, and video-based marketing materials, as well as other Collins Dental publications. I hereby release Collins Dental, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Printed Name: _____ Date: 11/06/2021

Signature: _____Date: 11/06/2021

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CollinsDentalCare.com

Record of Treatment

Providers

Hyg/Assist: _____ Dr: _____

	Procedure	Code	Check if Completed
HYGIENE	Prophy	D1110	
	Debridement	D4355	
LOE	LOE	D0140	
	4 BWX	D0274	
	PA	D0220	
	Addtnl PA	D0230	
	Pano	D0330	
POSTERIOR	1 Surface	D2391	
	2 surface	D2392	
	3 surface	D2393	
	4 surfaces	D2394	
ANTERIOR	1 Surface	D2330	
	2 Surface	D2331	
	3 Surface	D2332	
	4 Surface	D2335	
EXTRACTION	Simple	D7140	
	Surgical	D7210	

CHART NOTE:

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