



The Art of Dentistry

Valeria Soltanik, DMD P.A.

2999 NE 191st street Suite 350
Aventura, FL 33180
305-466-2334

Patient No. []

Patient's Name Last First Middle

Address Street Apt. City State Zip Code

How long at this address? Driver's License No.

Home Phone Work Phone Fax

Mobile Beeper E-Mail

Sex (M/F) Marital Status Social Security No Birth Date M / D / Y

Insurance: Yes / No Insurance Company SS # of Subscriber

Employer Occupation No. Years employed

How were you referred to our office?

RESPONSIBLE PARTY

Name Last First Middle

Address Street Apt. City State Zip Code

How long at this address? Driver's License No. Relationship to Patient

Home Phone Work Phone Fax

Mobile Beeper E-Mail

Sex (M/F) Marital Status Social Security No Birth Date M / D / Y

Employer Occupation No. Years employed

REPRESENTATIONS

- 6. I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN (INCLUDING MY MEDICAL HISTORY ON PAGE 2) IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM TO THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.
7. I AUTHORIZE THIS OFFICE TO VERIFY MY AND MY SPOUSE'S CREDIT STATUS PRIOR TO EXTENDING CREDIT FOR TREATMENT AND AT THE DISCRETION OF THIS OFFICE, TO USE THE SERVICE OD ONE OR MORE CREDIT REPORTING SERVICES.
8. IF THIS OFFICE ACCEPTS INSURANCE, I AUTHORIZE PAYMENT DIRECTLY TO THIS OFFICE OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO ME AND I ASSIGN ANY AND ALL THE BENEFITS TO THIS OFFICE, AND I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED AND AM ALSO RESPONSIBLE FOR PAYING ANY CO-PAYMENT AND DEDUCTIBLES THAT MY INSURANCE DOES NOT COVER.
9. IF COLLECTION EFFORTS ARE UNDERTAKEN DUE TO MY FAILURE TO PAY ANY AND ALL THE FEES TO THIS OFFICE, I AGREE TO BE RESPONSIBLE FOR ANY ATTORNEY'S FEES AND COSTS INCURRED IN CONNECTION WITH SUCH COLLECTION EFFORTS. I ALSO UNDERSTAND THAT I WILL BE CHARGED INTEREST AT THE RATE OF 1.5% PER MONTH ON ANY OUTSTANDING BALANCE (or the maximum allowed by the law).
10. I CONSENT TO AND AUTHORIZE TREATMENT RECOMMENDED BY THE DENTAL STAFF.

PATIENT SIGNATURE (PARENT'S SIGNATURE IF MINOR)

DATE



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Does your medical history include any of the following?

YES NO

- Are you in good health?
- Has your health changed within the past year? Explain _____
- My physician's name and phone number is _____
- Have you ever had any serious illness or operations?
- Damaged or artificial heart valves; rheumatic fever?
- Heart or cardiovascular disease (heart attack, angina)?
- High or low blood pressure? Explain _____
- Abnormal bleeding?
- Stroke?
- Circulatory problems?
- Allergies to medicines or drugs? If yes, what? _____
- Chest pains?
- Sinus trouble?
- Asthma or hay fever?
- Fainting spells or seizures?
- Diabetes? If yes, what was your last sugar level? _____ When was it taken _____
- Hepatitis, jaundice or liver disease? Explain _____
- Aids or HIV Infection?
- Thyroid problems?
- Respiratory problems, emphysema or bronchitis?
- Kidney trouble?
- Tuberculosis?
- Sexually transmitted disease? Explain _____
- Epilepsy or other neurological disease?
- Problems with mental health or nervous problems?
- Cancer? Explain _____
- Radiation treatments for cancer, tumors or growths?
- Problems with previous dental treatment?
- Allergic to penicillin, erythromycin or codeine?
- Pregnant or nursing?
- Are you taking birth control pills?
- Do you have any other health concerns not mentioned? Explain _____
- List any drugs you are presently taking _____
- Pharmacy name and telephone number _____

PATIENT CONTACT INFORMATION

IN CASE OF EMERGENCY, PLEASE NOTIFY _____
Name Phone

WE WILL CONFIRM YOUR APPOINTMENT BETWEEN 9:00 A.M. AND 3:00 P.M. THE DAY BEFORE SCHEDULED. AT WHAT PHONE NUMBER WILL WE BE ABLE TO CONTACT YOU DURING THESE HOURS? _____
IF YOU CANNOT BE REACHED BY TELEPHONE DURING THESE HOURS, HOW AND WHERE CAN WE CONTACT YOU TO CONFIRM YOUR APPOINTMENT? _____

DOCTOR'S NOTES