Scott Q. Bryington, D.D.S.
37153 State Road 54
Zephyrhills, Florida 33542-9635
(813) 788-0451

Welcome,

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care at reasonable prices, and proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

We would appreciate it if you would complete the Patient Information Form and Medical History Form before your arrival. Please remember to bring it with you at the time of your appointment along with your Dental Insurance card and List of Medications.

If you require Premedication for an artificial joint replacement or heart condition or a recommendation from your physician, please contact the office and see the Premed Link under “CARE INFO” on our website.

For driving directions to our office, click “MAP”.

Thanks again for choosing our dental practice.

Sincerely,

Dr. Bryington and Staff

SCOTT Q. BRYINGTON, D.D.S.

PATIENT ACQUAINTANCE FORM

WELCOME...My staff and I are pleased to welcome you to our office. We look forward to providing you and your family with the most modern dental care available. Our office can provide you with complete general dental service, from cleaning to cosmetic dentistry to full mouth reconstructive care.

PATIENT INFORMATION

Name _____ Preferred Name_____

Local Address _____ Other Address _____
City,State, Zip _____ City, State, Zip_____

Home Phone # _____ Sex: Male _____ Female _____
Work Phone # _____ Soc. Sec. # _____
Cell Phone # _____ Birth date _____
Email _____ Marital Status _____
Driver's License # _____ Spouse Name_____

If child: Parent/Guardian: _____ Parent/Guardian #2_____

In Case of Emergency:
Name _____ Phone # _____

Whom may we thank for referring you to our office?_____

EMPLOYMENT

Patient/Parent Employer _____ Spouse/Parent Employer _____
Employer Address _____ Employer Address _____
City, State, Zip _____ City, State, Zip _____
Phone # _____ Phone # _____

DENTAL INSURANCE

Name of Dental Insurance Co. _____
Group # _____ Claims Telephone _____
Secondary Dental _____
Group # _____ Claims Telephone _____

INSURED INFORMATION

Insured Name _____ Home Phone _____
Address _____ Work Phone _____
City, State, Zip _____
SS# _____ Date of Birth _____
Insurance ID# _____
Employer Name _____

EMERGENCY CARE. . . We recognize that emergency situations do arise and we will do our best to respond promptly. If you do have a problem, please call us as early in the day as possible. For after hour emergencies call the office number for instructions.

PREVENTIVE CARE. . . Good dental health requires constant attention. Regular preventive health care is a sound investment. We urge you to do your share by brushing and flossing daily and visiting our office at the recommended intervals for routine preventive care. For recall visits you will be contacted by mail. Please telephone for an appointment when you receive this notice.

PAYMENT. . . We expect payment at the time of service. For your convenience MasterCard, Visa, Discover and Care Credit are accepted.

INSURANCE . . . As a service to you, our office will submit charges for service to your insurance company. However, we do consider the patient/guardian primarily responsible for the account. When insurance claims are preauthorized and benefits are assigned to us, the portion of the fee which is payable by the patient is due at the time of service.. If insurance payment is not received within 30 days of the date of service, the patient will be responsible for the account balance at that time.

CONSENT FOR PROCEDURE

This is to certify that I, undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

PATIENT/or Guardian Signature_____ Date _____

PRIVACY POLICY NOTICE

Dear Patient:

Federal law requires us, as your health provider to make a copy of our Privacy Policy available to you. We are glad to have this opportunity to do so and to communicate to you our commitment to guard against inappropriate disclosure of your personal information.

We collect and use information necessary to provide you with dental health services. We collect and maintain information including your name, address, telephone number, age, medical history, insurance information and other pertinent information needed for your care. This information will not be disclosed to anyone except as permitted by law. When this information about you, as permitted by law, is shared, we protect it with a confidentiality agreement that obligates the recipient of the information to keep it confidential. This confidential information will be stored in a secure place, disposed of in a secure fashion and used only for the purpose for which it was provided.

I acknowledge that I have read the above office Privacy Policy and have had a copy of the office Privacy Policy made available to me.

PATIENT/or Guardian Signature_____ Date _____

PATIENT NAME_____

MEDICAL HISTORY

Name of Medical Doctor: _____ Phone_____
Drugs, pills or medications you are taking. Please list or provide copy: _____
_____

YES	NO		**Does your medical history include the following? Underline any that apply.**
___	___	1.	Do you have asthma, hay fever, sinusitis or any other allergies?
___	___	2.	Are you allergic to penicillin, aspirin, or other drugs? If so, what?_____
___	___	3.	Do you have blood pressure or heart problems?
___	___	4.	Have you had rheumatic fever, heart murmur or mitral valve prolapse?
___	___	5.	Have you had open heart surgery, heart valve replacement or a pacemaker?
___	___	6.	Do you have diabetes, liver, kidney, thyroid or lung problems?
___	___	7.	Do you have ulcers or stomach problems?
___	___	8.	Have you ever had hepatitis or jaundice?
___	___	9.	Have you had a joint replacement? _____ When _____
___	___	10.	Do you have bleeding or clotting disorders or slow healing?
___	___	11.	Do you have arthritis?
___	___	12.	Have you ever had a venereal disease or herpes?
___	___	13.	Do you have AIDS or HIV+?
___	___	14.	Have you ever had a serious accident involving head injuries?
___	___	15.	Are you presently under the care of a physician?
		16.	When was your last physical exam? _____
___	___	17.	Have you ever been hospitalized? Why?_____
___	___	18.	Have you ever had radiation treatments or chemotherapy?
___	___	19.	Women - Are you pregnant?
___	___	20.	Women - Are you taking oral contraceptives, birth control?

DENTAL HISTORY

YES	NO		**Do you have any specific dental concerns?** Please list: _____
		21.	When was your last dental exam? _____
		22.	When was your last full mouth x-ray taken? _____
___	___	23.	Do you have pain in your jaw or near your ears?
___	___	24.	Do you get lip sores (fever blisters, cold sores)?
___	___	25.	Do you have any growths or sore spots in your mouth?
___	___	26.	Does any part of your mouth hurt when clenched?
___	___	27.	Have you ever had a problem with Novocaine or other local anesthetic?
___	___	28.	Have you ever had an allergic reaction to local anesthetic?
___	___	29.	Have you ever had any difficult extractions in the past?
___	___	30.	Have you experienced prolonged bleeding after extraction?
___	___	31.	Do your gums bleed?
___	___	32.	Do you have a bad taste in your mouth or mouth odor?
___	___	33.	Have you ever had instructions on the care of your mouth?
___	___	34.	Do you chew on only one side of your mouth? If so, why? _____
___	___	35.	Do you habitually clench or grind your teeth?
___	___	36.	Is any part of your mouth sensitive to pressure, hot or cold? Where? _____
___	___	37.	Do you have headaches that you associate with your teeth?
___	___	38.	Do you like your smile?
___	___	39.	Do you like the color of your teeth?
___	___	40.	Is there any other problem not covered? _____
		41.	When was your last cleaning? _____
		42.	How many times a day do you brush your teeth? _____
___	___	43.	Do you floss daily? How often? _____
___	___	44.	Do you use any oral rinses? What? _____
___	___	45.	Do you smoke? Packs per day? _____ How many years? _____
___	___	46.	Do you use chewing tobacco or snuff?
___	___	47.	Do you still have your wisdom teeth?
___	___	48.	Have you had gum problems in the past?
___	___	49.	Have you had gum surgery or treatment?
___	___	50.	Have you ever had braces/orthodontic treatment?
___	___	51.	Have you ever had TMJ treatment or problems?
___	___	**52.**	**Are your teeth sensitive?**