



Elite Dental Club
Implant Center & General Dentistry
Dr. Raouf Morcos, DDS
4556 Warm Springs Ave Wildwood FL 34785
Phone 352-670-4777 ♦ Fax 352-577-9646

Patient Registration (Please Print Clearly)

Name: _____ DOB _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child

Address (street, city, state, zip): _____

Phone Number: _____

Email Address: _____
(By providing an email address we assume its okay to email appointment reminders, insurance claims etc.)

Primary Care Physician: _____

Phone Number: _____

Emergency Contact: _____

Phone Number: _____

List of Current Medications: _____

Do you have any allergies to any medications? Yes No

Are you allergic or do you react adversely to any of the following;

Yes	No	Aspirin		Yes	No	Local Anesthetics (Novocain)
Yes	No	Acrylic		Yes	No	Metal
Yes	No	Barbiturates, sedatives/sleeping pills		Yes	No	Milk Protein
Yes	No	Codeine		Yes	No	Sulfa Drugs
Yes	No	Latex		Yes	No	Tetracycline
Yes	No	Penicillin or another antibiotic? If yes please specify:				

Do you require antibiotics prior to dental procedures? Yes No

Any current major medical problems at this time that the Doctor should be made aware of? Yes No

Do you have dental insurance? Yes No

Dental History

Yes No	Are you experiencing any discomfort? If yes, how would you rate your discomfort from 1-10, with 10 being the highest?	Pain level. Please circle one 1 2 3 4 5 6 7 8 9 10
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How would you rate your smile on a scale of 1 to 10, with 10 being the highest?	1 2 3 4 5 6 7 8 9 10
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Yes No	Do you snore?	Yes No	Do you take a fluoride supplement?
Yes No	Do you have bleeding gums?	Yes No	Do you use tobacco (smoke or chew)?
Yes No	Do you have bad breath?	Yes No	Do you drink coffee or tea?
Yes No	Do you grind your teeth?	Yes No	Do you bite pencils?
Yes No	Do you play sports?	Yes No	Do you grind your teeth at night?
Yes No	Do you suck your thumb?	Yes No	Do you have any missing teeth?
Yes No	Have you ever worn braces?	Yes No	Do you bite your nails?
Yes No	Are you interested in clear aligners?	Yes No	Do you bite your lips?
Yes No	Are you sensitive to hot, cold, or sweets?	Yes No	Interested in having whiter/brighter teeth?
Yes No	Do you have difficulty brushing your teeth?	Yes No	Have you ever had an accident that damaged your teeth?
Yes No	Have you ever received Periodontal (Gum) Therapy?	Yes No	Does your jaw pop or do you hear clicking when chewing?

Medical History

Yes No	Are you under a physician's care?	Yes No	Have you been hospitalized or had a major operation?
Yes No	Have you had serious head or neck injury?	Yes No	Do you use controlled substances?
Yes No	Do you use recreational substances?	Yes No	Women: Are you pregnant, trying to get pregnant, or breast feeding?

If you answered yes to any of the about, please explain:

Are you currently or have you taken any of the following medications and/or supplements in the past 12 months;

Yes No	Anticoagulants	Yes No	Herbal Supplements
Yes No	Aspirin-Daily	Yes No	Insulin or Diabetes
Yes No	Contraceptives	Yes No	Nitroglycerine
Yes No	Heart Medications	Yes No	Phen-Fen or Redux
Yes No	High Blood Pressure Medication	Yes No	Tranquilizer
Yes No	Bisphosphonates (used to treat osteoporosis, such as Fosamax, Boniva, Actonel, and Zometa)		
Yes No	Antibiotics or Sulfa Drugs: if yes please specify;		

Do you currently have or previously had;						
Yes	No	AIDS/HIV Positive		Yes	No	Hepatitis B or C
Yes	No	Alzheimer's Disease		Yes	No	Herpes
Yes	No	Anaphylaxis		Yes	No	High Blood Pressure
Yes	No	Anemia		Yes	No	Hives/Rash
Yes	No	Angina		Yes	No	Hypoglycemia
Yes	No	Arthritis/Gout		Yes	No	Human Papillomavirus
Yes	No	Artificial Heart Valve		Yes	No	Irregular Heart Beat
Yes	No	Asthma		Yes	No	Kidney Problems
Yes	No	Artificial Joint		Yes	No	Leukemia
Yes	No	Blood Disease		Yes	No	Liver Disease
Yes	No	Blood Transfusion		Yes	No	Low Blood Pressure
Yes	No	Breathing Problem		Yes	No	Lung Disease
Yes	No	Bruise Easily		Yes	No	Mitral Valve Prolapse
Yes	No	Cancer		Yes	No	Osteoporosis
Yes	No	Chemotherapy		Yes	No	Pain in Jaw Joints
Yes	No	Chest Pains		Yes	No	Parathyroid Disease
Yes	No	Cold Sores/Fever Blisters		Yes	No	Parkinson's Disease
Yes	No	Congenital Heart Disorder		Yes	No	Pins/Rods/Stints /Shunts
Yes	No	Convulsions		Yes	No	Psychiatric Care
Yes	No	Cortisone Medicine		Yes	No	Radiation Treatments
Yes	No	Diabetes		Yes	No	Recent Weigh Loss
Yes	No	Drug Addiction		Yes	No	Renal Dialysis
Yes	No	Easily Winded		Yes	No	Rheumatic Fever
Yes	No	Emphysema		Yes	No	Rheumatoid Arthritis
Yes	No	Endocarditis		Yes	No	Scarlet Fever
Yes	No	Epilepsy/Seizures		Yes	No	Shingles
Yes	No	Excessive Bleeding		Yes	No	Sickle Cell Disease
Yes	No	Excessive Thirst		Yes	No	Sinus Problem
Yes	No	Fainting Spells/Dizziness		Yes	No	Sleep Apnea
Yes	No	Frequent Cough		Yes	No	Spinal Bifida
Yes	No	Frequent Diarrhea		Yes	No	Stomach/Intestinal Disease
Yes	No	Frequent Headaches		Yes	No	Stroke
Yes	No	Glaucoma		Yes	No	Swelling of Limbs
Yes	No	Hay Fever		Yes	No	Thyroid Disease
Yes	No	Heart Attack		Yes	No	Tonsillitis
Yes	No	Heart Murmur		Yes	No	Tuberculosis
Yes	No	Heart Pacemaker		Yes	No	Tumors or Growths
Yes	No	Heart Trouble/Disease		Yes	No	Ulcers
Yes	No	Hemophilia		Yes	No	Venereal Disease
Yes	No	Hepatitis A		Yes	No	Yellow Jaundice

X-Rays & Pictures

All x-rays/pictures taken at Elite Dental Club are complementary and are utilized in house ONLY. In the event a request to be removed from the office there is a \$250 charge, (two hundred fifty dollars).

Signature: _____ Date: _____

Patient Understanding & Agreement

Insurance

All treatment recommendations are based solely on the patients' dental needs and the best course of care, not on what is covered by insurance.

Elite Dental Club

- does not accept any form of insurance.
- will provide the patient, via email, with a completed American Dental Association (ADA) form, and its supporting documentation, within 3 weeks from appointment.
- will hold the original ADA form at the front desk for 1 month, please feel free to stop by at the front desk to pick it up if interested.

The Patient

- is responsible to consult with their insurance company regarding their benefits and filing procedures.
- is responsible to make sure their section(s) on the ADA form is filled out completely and correctly.

In the event Elite Dental Club is in receipt of a patient reimbursement the office will notify the carrier to reissue directly to patient and will also notify the patient.

Credit Card Fees

Effective June 01, 2024, there will be a 3.5% surcharge applied to all credit card transactions.

Cancellation/No Show

Effective January 01, 2025, there will be a \$25 fee for any cancellation/no show without providing a 48-hour notice.

Medical Information Release Form (HIPAA Release)

Release of Information: I authorize the release of information including the diagnosis, records, appointments, examination results, medication dose changes, and claims information.

This information may be released to:

☐ - Spouse _____ ☐ - Child(ren) _____

☐ - Other _____

Messages Please call _____

If unable to reach me: ☐ - Leave a detailed message OR ☐ - Leave a message asking me to return your call

E-mail Messages

☐ - Use my e-mail address to send messages. My e-mail address is _____

This Release of Information will remain in effect until terminated by me in writing. This release specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Signature: _____ Date: _____