

Name: _____

Home Phone No.: (_____) _____ - _____

Address: _____

Cell Phone No.: (_____) _____ - _____

Work Phone No.: (_____) _____ - _____

Social Security No.: _____ - _____ - _____

(City) (State / Zip)

Date of Birth: _____ - _____ - _____ (mm/dd/yy)

E-mail : _____

Dental Insurance Information

Insurance Company: _____ Insurance's Phone No.: _____

Primary Policy Holder: _____ Place of Employment: _____
(Name) (Policy Holder)

Insured's Social Security No.: _____ Insured's Date of Birth: _____

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

Patient's Signature

Legal Guardian

Date

HEALTH HISTORY

Patient's name: _____ Birth Date: _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

- | | | | |
|----|-----|----|--|
| 1. | Yes | No | Is your general health good? |
| 2. | Yes | No | Has there been a change in your health within the last year? |
| 3. | Yes | No | Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____ |
| 4. | Yes | No | Are you being treated by a physician now? For what? _____
Date of last medical exam? _____ Date of last Dental exam _____ |
| 5. | Yes | No | Have you had problems with prior dental treatment? |
| 6. | Yes | No | Are you in pain now? |

II. HAVE YOU EXPERIENCED:

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|------------------------|
| 7. | Yes | No | Chest pain (angina)? | 18. | Yes | No | Dizziness? |
| 8. | Yes | No | Swollen ankles? | 19. | Yes | No | Ringing in ears? |
| 9. | Yes | No | Shortness of breath? | 20. | Yes | No | Headaches? |
| 10. | Yes | No | Recent weight loss, fever, night sweats? | 21. | Yes | No | Fainting spells? |
| 11. | Yes | No | Persistent cough, coughing up blood? | 22. | Yes | No | Blurred vision? |
| 12. | Yes | No | Bleeding problems, bruising easily? | 23. | Yes | No | Seizures? |
| 13. | Yes | No | Sinus problems? | 24. | Yes | No | Excessive thirst? |
| 14. | Yes | No | Difficulty swallowing? | 25. | Yes | No | Frequent urination? |
| 15. | Yes | No | Diarrhea, constipation, blood in stools? | 26. | Yes | No | Dry mouth? |
| 16. | Yes | No | Frequent vomiting, nausea? | 27. | Yes | No | Jaundice? |
| 17. | Yes | No | Difficulty urinating, blood in urine? | 28. | Yes | No | Joint pain, stiffness? |

III. DO YOU HAVE OR HAVE YOU HAD:

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|-----------------------------|
| 29. | Yes | No | Heart disease? | 40. | Yes | No | AIDS |
| 30. | Yes | No | Heart attack, heart defects? | 41. | Yes | No | Tumors, cancer? |
| 31. | Yes | No | Heart murmurs? | 42. | Yes | No | Arthritis, rheumatism? |
| 32. | Yes | No | Rheumatic fever? | 43. | Yes | No | Eye diseases? |
| 33. | Yes | No | Stroke, hardening of arteries? | 44. | Yes | No | Skin diseases? |
| 34. | Yes | No | High blood pressure? | 45. | Yes | No | Anemia? |
| 35. | Yes | No | Asthma, TB, emphysema, other lung diseases? | 46. | Yes | No | VD (syphilis or gonorrhea)? |
| 36. | Yes | No | Hepatitis, other liver disease? | 47. | Yes | No | Herpes? |
| 37. | Yes | No | Stomach problems, ulcers? | 48. | Yes | No | Kidney, bladder disease? |
| 38. | Yes | No | Allergies to: drugs, foods, medications, latex?
List: _____ | 49. | Yes | No | Thyroid, adrenal disease? |
| 39. | Yes | No | Family history of diabetes, heart problems, tumors? | 50. | Yes | No | Diabetes? |

IV. DO YOU HAVE OR HAVE YOU HAD:

- | | | | | | | | |
|-----|-----|----|-------------------------|-----|-----|----|---------------------|
| 51. | Yes | No | Psychiatric care? | 56. | Yes | No | Hospitalization? |
| 52. | Yes | No | Radiation treatments? | 57. | Yes | No | Blood transfusions? |
| 53. | Yes | No | Chemotherapy? | 58. | Yes | No | Surgeries? |
| 54. | Yes | No | Prosthetic heart valve? | 59. | Yes | No | Pacemaker? |
| 55. | Yes | No | Artificial joint? | 60. | Yes | No | Contact lenses? |

V. ARE YOU TAKING:

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|----------------------|
| 61. | Yes | No | Recreational drugs? | 63. | Yes | No | Tobacco in any form? |
| 62. | Yes | No | Drugs, medications, over-the-counter medicines
(including Aspirin), natural remedies? | 64. | Yes | No | Alcohol? |

Please list: _____

VI. WOMEN ONLY:

- | | | | | | | | |
|-----|-----|----|--|-----|-----|----|-----------------------------|
| 65. | Yes | No | Are you or could you be pregnant or nursing? | 66. | Yes | No | Taking birth control pills? |
|-----|-----|----|--|-----|-----|----|-----------------------------|

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ Date: _____

RECALL REVIEW:

1. Patient's signature _____ Date: _____

STEVEN G. MAUTNER, D.D.S., P.A.
5609 NW 29TH STREET
MARGATE, FL 33063
(954) 978-8866

CONSENT FOR DENTAL TREATMENT - II

Page 1 of 2

Patient's Name

Date

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____ 1. **TREATMENT:**

I understand I am having the following dental treatment performed:

- Fillings Crowns Bridges Dentures Extractions
 Impacted tooth removal Root Canals Other

_____ 2. **Drugs and Medications:**

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

_____ 3. **Fillings:**

I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement.

_____ 4. **Crowns and Bridges:**

I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication of the restoration. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I understand I may need further treatment by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

_____ 5. **Dentures:** I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent." Sore spots, altered speech and difficulty eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustment and one or more permanent relines within several months. I understand that failure to keep appointments may result in a less desirable result. If remake is required due to my delay, additional fees may be incurred.

_____ 6. **Extractions:** Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. It is my understanding that the following teeth will be remove: _____ I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I have been told that the risks of removing teeth include, but are not limited to: pain, swelling, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip and or other facial areas, cheek, tongue, gums and teeth. Such numbness may be temporary or permanent. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

STEVEN G. MAUTNER, D.D.S., P.A.
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(954) 978-8866

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

The undersigned acknowledges disclosure of the currently effective Notice of Privacy Practices for Steven G. Mautner, D.D.S, P.A., this _____ day of _____, 2026.
A copy of this signed, dated Acknowledgment shall be as effective as the original.

PLEASE PRINT YOUR NAME

PLEASE SIGN YOUR NAME

If you are the legal representative of the patient, please print the patient's name and describe your authority:_____.

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

- ___ It was emergency treatment.
- ___ I could not communicate with the patient.
- ___ The patient refused to sign.
- ___ The patient was unable to sign because _____

___ Other (please describe): _____

Signature of privacy officer: _____

STEVEN G. MAUTNER, D.D.S., P.A.
5609 NW 29th Street
Margate, FL 33063
Office (954) 978-8866
Fax (954) 978-0618

OUR FINANCIAL POLICY

We welcome you to our practice. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign at this time. All patients must complete our "Patient Information Form" before seeing the Doctors.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD DISCOVER AND AMERICAN EXPRESS

PPO: Filing insurance claims and accepting assignment is a service provided without charge and in no way relieves you of responsibility of your bill. We cannot guarantee any payments to be made by your insurance company. You must understand that you are still responsible for your account. If your insurance company fails to pay, you will be responsible for that amount.

PPO/ HMO/CASH PT'S: your co-pay must be paid at the time of service. In some instances, HMO policies will pay for some procedures and you must understand that you are still responsible for your account. If your insurance company fails to pay, you will be responsible for that amount. We cannot guarantee any payments to be made by your insurance company. All balances on accounts are the sole responsibility of the Patient and/or Guardian.

UCR (USUAL and CUSTOMARY): Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. In the event that you default on your payments, we may have to seek help from a Collection Agency. If this situation should occur, you will be responsible for any and all collection fees as well as your existing balance.

A fee of \$25.00 will be charged for returned checks.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE NOTE THAT WE CANNOT GUARANTEE ANY PAYMENTS TO BE MADE BY YOUR INSURANCE COMPANY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.

I HAVE READ THE FINANCIAL POLICY AND AGREE TO IT.

Patient's Signature _____ Date _____

Patient's Full Name _____

Patient's Address _____

Patient's Phone Number _____