LAS SENDAS DENTAL HEALTH

ABOUT YOU

E-Mail Address: _____

Name: _____
Last First M.I.

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____ **Age:** _____ **SS #** _____

Home Address: _____

_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm # : (___)_____ **Cell # :** (___)_____

Wk # ; (___)_____ **Ext :** _____ **Dr Lic # :** _____

Employer: _____

Employer's Address: _____

City: _____ **State:** _____ **Zip:** _____

How long there? _____ **Occupation:** _____

Best time & Phone # to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous Dentist: _____

Address and Phone # : _____

Last Visit Date: _____ **Reason:** _____

Neighbor or Relative not living with you.

Name: _____ **Relation:** _____

Hm # : (____)_____ **Cell # :** _____

Address: _____

_____

YOUR SPOUSE

Name: _____

Employer: _____

Wk # (___)_____ **Ext:** _____ **SS #** _____

Birthdate: _____ **Dr. Lic #** _____

INSURANCE

Insurance Co Name : _____

Insurance Co Address:_____

Insurance Co Phone #: (___)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ **Relation:** _____

Insured's Birthdate: _____ **Insured's SS #** _____

Insured's Employer: _____

Insured's Address: _____

SECONDARY INSURANCE

Insurance Co Name : _____

Insurance Co Address:_____

Insurance Co Phone #: (___)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ **Relation:** _____

Insured's Birthdate: _____ **Insured's SS #** _____

Insured's Employer: _____

Insured's Address: _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage and assign directly to Las Sendas Dental Health all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. Insurance Estimates are provided as a courtesy. In the event that my insurance carrier pays less than the estimated amount, I am responsible for the unpaid balance

_____
Responsible Party Signature

_____ _____
Relationship **Date**

Please complete this section when the responsible party for the account is not listed on the form.

Person Responsible for the account: _____

Hm # : (___) _____ **Ext:** _____ **Cell #:** _____

Billing Address: _____

Relationship: _____

Employer: _____ **Emp Phone #** _____

Driver License # : _____

Medical / Dental History

Do you have a personal physician? ____ Yes ____ No
Physician's Name: _____
Address: _____
Phone #:_____ Date of last visit: _____
Would you consider yourself to be in fairly good health?
___ Yes ___ No

Y N Are you currently under the care of a physician?
Y N Have you been hospitalized within the last 5 yrs?
Y N Are you currently taking any prescription medications, vitamins or supplements?
Y N Do you have a history or currently use tobacco?
Y N Do you have a family history of heart disease or Diabetes?
Y N Do you have any other conditions, diseases, etc.?
If any of the previous questions are yes, please explain?

List all medications and supplements that you are taking.

Women only: Are you pregnant? ____ Yes ____ No
If yes, when is the due date?_____
Are you nursing? _____

Please indicate if you have experienced any of the following:

- ☐ Pre-Med _____
- ☐ Alcohol/Drug Abuse
- ☐ Allergies
  - ☐ Aspirin
  - ☐ Codeine
  - ☐ Erythromycin
  - ☐ Hay Fever/seasonal
  - ☐ Latex
  - ☐ Penicillin
  - ☐ Sulfa
  - ☐ Gold
  - ☐ Fluoride
  - ☐ Jewelry
  - ☐ Metals
  - ☐ Tetracycline
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Thyroid Conditions
- ☐ Tumors
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epi Alert
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ High or Low Cholesterol
- ☐ Hard of Hearing
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes/Fever Blister
- ☐ High / Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Psychiatric Problems
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Do you have any other health issues or allergies? Please explain _____
_____

Do you like your smile? _____Yes _____No

Are you happy with the color of your teeth? ___Yes ____No

If there was something you could change about your smile, what would it be? _____

How frequently do you brush your teeth? ____ x's per _____

What type of toothbrush do you use?

☐ Manual ☐ Sonicare ☐ Oral B Braun ☐ Other

How frequently do you floss your teeth? _____x's per_____

Y N Do you have a history of Periodontal Disease: Ex. (Deep Cleaning/Gum Treatment/Scaling & Root Planing)?
Y N Do your gums bleed when you brush or floss:
Y N Do your teeth experience sensitivity to cold or hot temperatures?
Y N Are any of your teeth currently causing you pain?
Y N Are any of your teeth loose?
Y N Do you currently have any dental implants, dentures, or partials:
Y N Do you clench or grind your teeth (either consciously or during sleep)?
Y N Do your jaws ever feel tired or ache?
Y N Do you have noticeable wear on your teeth:
Y N Do you snore?
Y N Have you ever been diagnosed with sleep apnea?
Y N Have you ever or are currently in orthodontic treatment, if so, who is your Orthodontist?

If any of the previous questions are marked Yes, please explain:
_____
_____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

Privacy Practices Documentation (HIPAA)

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
Signature _____ Date _____

I verbally reviewed the medical / dental information above with patient named herein. Doctor's Initial: _____ Date: _____

Consent for Services

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient: _____

Financial Agreement

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by any insurance company.

A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that a waiver of any breach of any condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to patient: _____