

WE ARE PLEASED TO WELCOME YOU TO OUR PRACTICE, PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS COMPLETELY AS YOU CAN.

Patient Information

Date _____

Name _____ Phone() _____
First Last

Sex M ___ F ___ Birthdate _____

Soc. Sec. # _____ Driver License# _____

Child ___ Single ___ Married ___ Widowed ___ Separated ___ Divorced ___

Address _____ City _____ State _____ Zip _____

Employed by _____ Occupation _____

Has any other family member been here before? ___ Name _____ Relationship _____

If student, School name _____

Address _____ City _____ State _____ Zip _____

Insurance Name _____ Telephone # _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

Phone# () _____ Relationship _____

If patient is a child fill out next part

Responsible person _____ Relationship to Patient _____

Birthdate _____ Soc.Sec.# _____

Sex M ___ F ___ Single ___ Married ___ Widowed ___ Separated ___ Divored ___

Driver License# _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Employed by _____ Occupation _____

~ NEXT PAGE PLEASE ~

Dental History

Reason for Today's Visit _____

Date of last dental visit _____ Dentist Name: _____

Check if you have had problems with any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Broken fillings | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate date _____

List medications you are currently taking _____

Are you allergic to any medication? _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check if you have or have had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

I understand that payment is due in full at time of treatment unless prior arrangements have been approved.

Signature _____ Date _____

(If patient is a child, parent signature is needed)

OFFICE POLICIES

\$25 fee will be assessed on missed appointments with less than 24 hour notice, after 3 missed appointments without 24hrs notice we will no longer be able to schedule an appointment for you. Our time is very important as well as our committed patients.

I understand and acknowledge that I am financially responsible for the services provided for myself or the below named individual, regardless of insurance coverage on the day services are rendered. All fees are due and payable at the time of your appointment. For you convenience, we accept cash, check, MasterCard, Visa, American Express and Discover.

As a courtesy, we accept assignment of insurance benefits, allowing you to pay your deductible and/or estimated co-payment at the time of treatment.

I understand that my insurance policy is a contract between my insurance provider and myself, not between the insurance company and Dr. Perez.

I also understand that insurance policies vary greatly from one policy to the next and that Dr. Perez and her staff are not responsible for knowing all the details of my policy.

We have no control over insurance company's payment of claims. Any balance left unpaid by your insurance company 60 days after service is due in full by you.

I understand that Dr. Perez's office staff is authorized by Dr. Perez to file my insurance as a courtesy to me.

Our office always maintains quality sterilization procedures for your protection and safety as well as safeguarding our staff.

We reserve the right to assess fees for: Returned Checks (\$25), Duplication of records (\$12-20), outstanding collections (4%).

We provide services on an appointment basis. While we make every effort to be punctual, there will be emergencies or circumstances beyond our control that may delay our appointment schedule. Only one dentist is present to serve your dental needs. Your patience is appreciated.

Please notify the office staff if you have any special needs when you arrive.

I give my CONSENT to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending Dentist or by her supervised staff for diagnostic purposes or dental treatment.

The undersigned has read and accepts the above, and agrees to abide by all terms and conditions as stated.

Patient Signature: _____ Date: _____

(If patient is a child, parent signature is needed)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

1. The right to request and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to report of disclosures of your information;
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice of Privacy Practice contains information about how we will insure that your information remains private.

Please list all telephone numbers where we may contact you:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

PLEASE LIST THE NAMES OF ALL PEOPLE (e.g. SPOUSE, PARENTS, GRANDPARENTS, ETC...) YOU AUTHORIZE S TO RELEASE YOUR HEALTH INFORMATION TO, INCLUDING COPIES OF YOUR RECORDS IF NEEDED:

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Acknowledgement of Notice of Privacy Practice

I hereby acknowledge that I have reviewed this practices's Notice of Privacy Practice. I further understand that the practice will offer me updated to this Notice of Privacy Practice. Should it be amended, modified or changed in any way I will receive a copy.

Printed Name of Patient
