Perez Family Dental
Azzah Mary Perez, D.D.S.
1551 W. Berry St. ❍ Fort Worth, Texas 76110
Ph: 817-922-8552 ❍ Fax: 817-922-8572

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___ Divorced__

Driver License#_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Employed by_____ Occupation_____

~ NEXT PAGE PLEASE ~

Perez Family Dental
Azzah Mary Perez, D.D.S.
1551 W. Berry St. ❍ Fort Worth, Texas 76110
Ph: 817-922-8552 ❍ Fax: 817-922-8572

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:

____Bad Breath	____Grinding teeth	____Sensitivity to hot
____Bleeding gums	____Loose teeth	____Sensitivity to sweets
____Clicking or popping jaw	____Broken fillings	____Sensitivity when biting
____Food collection between teeth	____Sensitivity to cold	____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:

___Anemia	___Cortisone Treatments	___Hepatitis	___Shortness of breath
___Arthritis, Rheumatism	___Cough, Persistent	___High Blood Pressure	___Skin Rash
___Artificial Heart Valves	___Diabetes	___HIV/AIDS	___Stroke
___Artificial Joints	___Epilepsy	___Jaw Pain	___Swelling
___Asthma	___Fainting	___Liver Disease	___Thyroid Problems
___Back Problems	___Glaucoma	___Kidney Disease	___Tobacco Habit
___Blood Disease	___Headaches	___Pacemaker	___Tonsillitis
___Cancer	___Heart Murmur	___Radiation Treatment	___Tuberculosis
___Chemotherapy	___Heart Problems	___Respiratory Disease	___Ulcer
___Circulatory Problems	___Hemophilia	___Rheumatic Fever	___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)

Perez Family Dental
Azzah Mary Perez, D.D.S.
1551 W. Berry St. ❍ Fort Worth, Texas 76110
Ph: 817-922-8552 ❍ Fax: 817-922-8572

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

_____