NEW PATIENT INFORMATION

*Welcome to **San Pedro Smiles**! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.*

Patient's name _____ Date of Birth_____ SS#_____

Cell phone _____ May we text you? Y/N Work phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

EMAIL ADDRESS: _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Dental Insurance Co._____ID #:_____ Group #: _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's DOB: _____ Social Security #: _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

Last Dental Appt: _____ Where?:_____

What is the reason for your visit today?_____

Signature of patient (or parent) _____ Date _____

Patient's Name:_____ Birthdate:_____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at ***SAN PEDRO SMILES***.

These procedures include, but are not limited to;
examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics.

I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.

This consent shall be considered in effect until rescinded or revoked.

_____ _____
(Print your name) (Date)

_____ _____
(Signature) (Date)

This section needs to be completed for children under the age of 18 by a parent or legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name:_____Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name:_____Relationship:_____

If child is over 17, please check one:

_ Since my child is over the age of 17, I also give permission for him/her to present for treatment unaccompanied by an adult. I understand that no invasive treatment, such as extractions or the initiation of root canal therapies, will be performed unless I am notified by telephone. In the event of an emergency, when I cannot be reached, I give permission to perform whatever therapies are deemed necessary by the treating provider.

_ Although my child is over 17, I wish to be present for all treatments performed.

_____
(Signature of parent or legal guardian)

This consent shall be considered in effect until rescinded or revoked

CONSENT FORM

I consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

1. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

2. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

3. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

4. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

5. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

I understand I will be notified of estimated costs and all treatment that will need to be done before treatment is actually performed.

***Signature*_____ *Date:*_____**

Office Financial Policy

Payment is expected at time of service. We will accept cash, check debit/credit card. Checks accepted with valid driver's license only. There will be a $35 service charge for returned checks.

We accept insurance and we will file your claims at no charge. It is the patients responsibility to provide us with current insurance information. If any payment from an insurance company becomes 30 days past due, you will be immediately billed for the entire balance.

We will file Pre-Treatment estimates at your request only. Please be aware that some insurance companies may not honor a pre-treatment estimate or may alter it. In all cases it may delay important dental care.

Not all services are covered by insurance. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Our staff can NEVER guarantee your eligibility and coverage.

Insurance limitations and regulations vary with all insurance plans. Therefore, if your insurance plan denies a service, you will be responsible for the complete charge. We do not base your treatment plan on what your insurance plan covers or does not cover. We are working for you, not the insurance company.

Past due accounts may be turned over to a collection agency. Any fees incurred due to this will be added to the outstanding balance. This may include late fees, collection agency fees, court fees, etc.

Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a charge for not showing up for scheduled appointments. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Signature_____ **Date:** _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request

Signature: _____ **Date: _____**