PATIENT INFORMATION

Patient Name: ______________________________ Date: _____/_____/______

SS#: _____-_____-______ D.O.B: ____/___/_____ DL#: _________________________

Home Address: ____

City: ________________________ State: ________ Zip: ________________

Home Phone: (____) _____-_________ Cell Phone: (____) _____-_________

Emergency Contact: ___________________________ Main Phone: (____) _____-_________

Email Address: ____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced

Are you an active user of any of the following? Please circle ALL that apply:

Facebook Google/Gmail Instagram Twitter

What is your preferred method of communication? Please circle ALL that apply:

Text Email Cell Phone Home Phone

Who should we thank for referring you?

☐ Patient (Name): ______________________________

☐ Google Search ☐ Facebook ☐ Yelp

☐ Instagram ☐ Our Website ☐ Other: ____________________________________

☐ Post Card ☐ Insurance

Please read carefully below

I, THE UNDERSIGNED HEREBY AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENTS DETERMINED NEEDS. I ALSO AUTHORIZE DENTAL HOUSE OF WELLINGTON TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK AND UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND ME, AND BETWEEN THE INSURANCE CARRIERS AND DENTAL HOUSE OF WELLINGTON, AND THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO DENTAL HOUSE OF WELLINGTON AND PAYMENTS RECEIVED BY THE DOCTOR FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT AND WILL BE REFUNDED TO ME, UPON REQUEST, IF I HAVE PAID THE DENTAL FEES INCURRED. I FURTHER UNDERSTAND THAT AN ADDITIONAL CHARGE WILL BE ADDED TO ANY OVERDUE BALANCE. I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICE AS REQUESTED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (“HIPAA”).

Patient Signature: ______________________________ Date: _____/_____/______

INSURANCE

Policy Holder: ______________________________

Birth Date: ____/____/______

SS#: _____-_____-_____

Relationship to Patient: ____________________

Employer: ______________________________

Insurance Company: ____________________

Subscriber ID#: __________________________

Group #: ______________________________

DENTAL HISTORY

Former Dentist: ______________________________

City/State: ______________________________

Date of last dental visit: ______________________

Date of Last X-Rays: ______________________

How often do you floss: ______________________

How often do you brush: __________________

Why did you leave your previous dentist: ____

Reason for your visit today: ____

Type of tooth brush? ☐ Soft ☐ Medium ☐ Hard ☐ Electric   Oral Irrigator? ☐ Yes ☐ No

Please check all that apply:

- ☐ Loose teeth/fillings
- ☐ Grinding teeth
- ☐ Sleep Apnea
- ☐ Jaw difficulty: Clicking/Pain
- ☐ Orthodontic Treatment
- ☐ Lip or cheek biting
- ☐ Frequent Headaches
- ☐ Periodontal Treatment
- ☐ Tooth pain
- ☐ Jaw, head or neck injuries
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Sensitivity to: ☐ Cold ☐ Hot ☐ Sweets ☐ When biting ☐ None

Do you have or have had any of the following:

☐ Dentures ☐ Partial Dentures ☐ Braces ☐ Invisalign™ ☐ Orthodontic retainer

YOUR SMILE

Is there anything about YOUR smile that you would like to change?

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces between teeth
- ☐ Replace silver fillings with tooth colored fillings
- ☐ Replace missing teeth
- ☐ Replace old crowns

How important is your dental health to you? (1 = not important……5 = extremely important)

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05

How would you rate your current dental health? (1 = bad……5 = excellent)

☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05

What are your long term dental goals?

____

____

How can we help you meet your goals?

____

____

MEDICAL HISTORY

Physicians Name: ______________________________ Date of last visit: _____/_____/______

Are you currently under medical treatment? ☐ Yes ☐ No

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No

If yes, please describe: ____

____

Please list any and all current or past medical conditions: ______________________________

____

Are you currently taking any medication? (including antibiotics) ☐ Yes ☐ No

If yes, please describe: ____

Do you smoke or use chewing tobacco? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Do you have any dental implants? ☐ Yes ☐ No

If yes, where? ____ (top, bottom, right, left)

Have you ever had any allergic reactions to the following:

☐ Local anesthetics ☐ Aspirin ☐ Latex/Sulfa ☐ Iodine

☐ Penicillin or other Antibiotics ☐ Nitrous Oxide ☐ Tetracycline ☐ Codeine

☐ Barbiturates (sleeping pills) ☐ Erythromycin ☐ Epinephrine ☐ Sulfa Drugs

Have you ever taken any of the following:

☐ Actonel ☐ Aredia ☐ Boniva ☐ Fosamax ☐ Reclast ☐ Zometa

☐ Herbal supplements ☐ Bisphosphonate ☐ Recreational drugs

Please check ALL that apply:

☐ Anemia
☐ Arthritis
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Bleeding
☐ Blood Disease
☐ Cancer
☐ Cardiovascular Disease
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Congenital Heart
☐ Cortisone Treatment
☐ Diabetes
☐ Epilepsy
☐ Fainting or Dizziness
☐ Glaucoma
☐ Heart Problems
☐ Headaches
☐ Heart Murmur
☐ Hepatitis - Type
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV Positive
☐ Hypoglycemic
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease Sinus
☐ Low Blood Pressure
☐ Mitral Valve Prolapsed
☐ Nervous Problems
☐ Pins, Plates, Screws
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Trouble
☐ Thyroid
☐ Tuberculosis
☐ Ulcers

Patient Signature: ______________________________ Date: _____/_____/______

NOTICE OF PRIVACY PRACTICE

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or if we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of October 17, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

☐ I do NOT authorize any information to be discussed with any family members or friends. ☐ I authorize information about treatment or appointments to

Be discussed with the following person: ___________________________ I have read and understand the above information.

Patient Signature: ___________________________ Date: _____/_____/______

FINANCIAL POLICY

Thank you for choosing DENTAL HOUSE of Wellington. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making cost of optimal care as easy and manageable for our patients as possible by offering several payments options.

PAYMENT OPTIONS

Check, Visa, MasterCard, American Express or Discover Card
Convenient Monthly Payment Options (1) from Citihealth or Carecredit
Allows you to pay over time with no annual fees or pre-payment penalties

Please note:

Dental House of Wellington requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. (2)

There is no fee for patients who miss or cancel appointments but we do ask that you give us a 24hour courtesy notice prior to your appointment.

Dental House of Wellington charges $30.00 for returned checks.

If you have any questions, please do not hesitate to ask.

(1) Subject to credit approval.
(2) If we do not receive payment from your insurance carrier within 30 days you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Have you ever had a dental appointment with Dr. Rojas at another location? ☐ Yes ☐ No

If YES, at what location? ____

Date: _____/_____/______

Patient Name (please print): ____

Patient/Parent or Guardian Signature: ____

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