Dr. Abel Aguilar DMD

Healthy Beautiful Smiles

Dr. Abel Aguilar, DMD LLC
404 West Perry St.
Manchester, GA 31816

Tel: 706-846-8404
Fax: 706-846-9182
Email: info@draguilar.com
Web: www.draguilar.com

ADULT

DATE_____

Full Legal Name_____
LAST FIRST MIDDLE

Nickname or name by which you want to be called._____

Marital Status: S M D W other _____

Date of Birth_____

Mailing Address_____
CITY STATE ZIP

Phone Number_____

Email Address_____

Employer's Name_____
Address_____
Phone Number_____
Your Occupation_____
Group Dental Insurance_____
COMPANY NAME POLYCY OR GROUP NUMBER

Address_____
_____

I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES INCURRED FOR SERVICES RENDERED BY DR. ABEL AGUILAR, DMD, LLC

SIGN_____

WITNESS_____

DATE_____

Dr. Abel Aguilar, DMD LLC
404 West Perry St.
Manchester, GA 31816

Tel: 706-846-8404
Fax: 706-846-9182
Email: info@draguilar.com
Web: www.draguilar.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the Office Manager.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Dr. Abel Aguilar DMD
Healthy ✦ Beautiful ✦ Smiles

Dr. Abel Aguilar, DMD LLC
404 West Perry St.
Manchester, GA 31816

Tel: 706-846-8404
Fax: 706-846-9182
Email: info@draguilar.com
Web: www.draguilar.com

Financial Arrangements

All patients, please read the following…

Payment for services is expected at the time service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. Cash and personal checks are accepted. If an extended payment plan is desired, please ask us about the CareCredit program. MasterCard and VISA credit card payment are also welcome. For charges of $500 or greater, a 5% courtesy will be extended for full cash (or check) payment in advance. If you have any questions, please feel free to ask.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added.

If you have dental insurance…

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have questions about "UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

_____ _____

Print Name Signature & Date

Dr. Abel Aguilar, DMD LLC
404 West Perry St.
Manchester, GA 31816

Tel: 706-846-8404
Fax: 706-846-9182
Email: info@draguilar.com
Web: www.draguilar.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of the **Notice of Privacy Practices** of this office.

_____
Name (Please Print)

_____
Signature

_____
Date

Please Note: It is your right to refuse to sign this acknowledgement.

_____

Office Use Only

We tried to obtain written acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices,** but could not be obtained because:

____An emergency prevented us from obtaining acknowledgement.
____A communication barrier prevented us from obtaining acknowledgement.
____The individual was unwilling to sign.
____Other (Please Specify):
_____
_____
_____
_____

ADA American Dental Association
www.ada.org

Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:

HEALTH HISTORY FORM

Name: Home Phone: ( ) Business Phone: ( )
LAST FIRST MIDDLE

Address: City: State: Zip Code:
P.O. BOX or Mailing Address

Occupation: Height: Weight: Date of Birth: Sex: M ❑ F ❑

SS#: Emergency Contact: Relationship: Phone: ( )

If you are completing this form for another person, what is your relationship to that person?
NAME RELATIONSHIP

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

	Yes	No	Don't Know
Do your gums bleed when you brush?	❑	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Do you have earaches or neck pains?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Do you wear removable dental appliances?	❑	❑	❑
Have you had a serious/difficult problem associated with any previous dental treatment?	❑	❑	❑

If yes, explain:

How would you describe your current dental problem?

Date of your last dental exam:

Date of last dental x-rays:

What was done at that time?

How do you feel about the appearance of your teeth?

MEDICAL INFORMATION

	Yes	No	Don't Know
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.			
Have you had any of the following diseases or problems?			
Active Tuberculosis	❑	❑	❑
Persistent cough greater than a 3 week duration	❑	❑	❑
Cough that produces blood	❑	❑	❑
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
Are you now under the care of a physician?	❑	❑	❑

If yes, what is/are the condition(s) being treated?

Date of last physical examination:

Physician:
NAME PHONE

ADDRESS CITY/STATE ZIP

NAME PHONE

ADDRESS CITY/STATE ZIP

	Yes	No	Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	❑	❑	❑

If yes, what was the illness or problem?

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	❑	❑	❑

If yes, what medicine(s) are you taking?

Prescribed:

Over the counter:

Vitamins, natural or herbal preparations and/or diet supplements:

	Yes	No	Don't Know
Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	❑	❑	❑
Do you drink alcoholic beverages?	❑	❑	❑

If yes, how much alcohol did you drink in the last 24 hours?

In the past week?

	Yes	No	Don't Know
Are you alcohol and/or drug dependent?	❑	❑	❑

If yes, have you received treatment? (circle one) Yes / No

	Yes	No	Don't Know
Do you use drugs or other substances for recreational purposes?	❑	❑	❑

If yes, please list:

Frequency of use (daily, weekly, etc.):

Number of years of recreational drug use:

	Yes	No	Don't Know
Do you use tobacco (smoking, snuff, chew)?	❑	❑	❑

If yes, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

	Yes	No	Don't Know
Do you wear contact lenses?	❑	❑	❑

PLEASE COMPLETE BOTH SIDES

Are you allergic to or have you had a reaction to?	Yes	No	Don't Know
Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Latex	❑	❑	❑
Iodine	❑	❑	❑
Hay fever/seasonal	❑	❑	❑
Animals	❑	❑	❑
Food (specify) _____	❑	❑	❑
Other (specify) _____	❑	❑	❑
Metals (specify) _____	❑	❑	❑

To yes responses, specify type of reaction.

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	❑	❑	❑

If yes, when was this operation done?

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?

	Yes	No	Don't Know
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑	❑

If yes, what antibiotic and dose?

Name of physician or dentist*:

Phone:

WOMEN ONLY

	Yes	No	Don't Know
Are you or could you be pregnant?	❑	❑	❑
Nursing?	❑	❑	❑
Taking birth control pills or hormonal replacement?	❑	❑	❑

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Abnormal bleeding	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Anemia	❑	❑	❑
Arthritis	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Asthma	❑	❑	❑
Blood transfusion. If yes, date: _____	❑	❑	❑
Cancer/Chemotherapy/Radiation Treatment	❑	❑	❑
Cardiovascular disease. If yes, specify below:	❑	❑	❑

____ Angina
____ Arteriosclerosis
____ Artificial heart valves
____ Congenital heart defects
____ Congestive heart failure
____ Coronary artery disease
____ Damaged heart valves
____ Heart attack
____Heart murmur
____High blood pressure
____Low blood pressure
____Mitral valve prolapse
____Pacemaker
____Rheumatic heart disease/Rheumatic fever

Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Disease, drug, or radiation-induced immunosurpression	❑	❑	❑
Diabetes. If yes, specify below:	❑	❑	❑

____ Type I (Insulin dependent) ____Type II

Dry Mouth	❑	❑	❑
Eating disorder. If yes, specify: _____	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/persistent heartburn	❑	❑	❑
Glaucoma	❑	❑	❑

	Yes	No	Don't Know
Hemophilia	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Recurrent Infections	❑	❑	❑

If yes, indicate type of infection: _____

Kidney problems	❑	❑	❑
Mental health disorders. If yes, specify: _____	❑	❑	❑
Malnutrition	❑	❑	❑
Night sweats	❑	❑	❑
Neurological disorders. If yes, specify: _____	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck			
Respiratory problems. If yes, specify below:	❑	❑	❑

____ Emphysema ____ Bronchitis, etc.

Severe headaches/migraines	❑	❑	❑
Severe or rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Sinus trouble	❑	❑	❑
Sleep disorder	❑	❑	❑
Sores or ulcers in the mouth	❑	❑	❑
Stroke	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Tuberculosis	❑	❑	❑
Thyroid problems	❑	❑	❑
Ulcers	❑	❑	❑
Excessive urination	❑	❑	❑

	Yes	No	Don't Know
Do you have any disease, condition, or problem not listed above that you think I should know about?	❑	❑	❑

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

FOR COMPLETION BY DENTIST

Comments on patient interview concerning health history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number	10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

SIGN & DATE ONLY

49. Provider ID	50. License Number	51. SSN or TIN

52. Phone Number ( ) –

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) Date

54. Provider ID	55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) –

58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org