

Patient Registration And Medical History

PLEASE PRINT

Date: _____

Patient: _____
Last Name First Name Middle Name Preferred Name

Street Address _____ City _____ State _____ Zip _____

Email: _____ Cell Phone (____) _____ Home Ph (____) _____

Sex M F Age _____ Birthdate _____ Married Single Minor Separated Divorced

Driver License # _____ Partnered for _____ years

Employer/School _____ Occupation _____

Employer Address _____ Work Ph (____) _____

Spouse/Parent Name _____ Spouse/ Parent Birthdate _____

Social Security # _____ Spouse/Parent's Social Security # _____

Name of Dental Insurance _____ ID# _____ Group# _____

In case of emergency, who should be notified? (Name and Ph#) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Please check any of the following that apply to you: Past or present

- AIDS
- Allergies (Seasonal)
- Anemia
- Arthritis
- Artificial Heart Valve
- Artificial Joints
- Asthma
- Back Problems
- Blood Disease
- Bruise Easily
- Cancer
- Chemotherapy
- Diabetes
- Dizziness
- Drug Addition
- Emphysema
- Endocarditis
- Excessive Bleeding
- Fainting
- Glaucoma
- Heart Conditions
- Heart Lesions (Congenital)
- Heart Murmur
- Heart Surgery

- Hepatitis A, B or C (Circle one)
- High/Low Blood Pressure (Circle One)
- HIV Positive
- Jaundice
- Jaw Joint Pain
- Kidney Disease
- Liver Disease
- Mitral Valve Prolapspe
- Nervousness/Depression
- Pacemaker
- Phen Fen (1 month +)
- Radiation (head/neck)
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Scarlet Fever
- Seizures/Epilepsy
- Sinus Problems
- Stomach Problems
- Stroke
- Swollen Neck Gland
- Thyroid Disease
- Tuberculosis
- Ulcers

- Venereal Diseases
- Other

Do you have any of the following drug allergies?

- Aspirin
- Penicillin
- Codeine
- Sulfa
- Valium
- Nitrous Oxide
- Tetracycline
- Latex
- Erythromycin
- Local Anesthetic
- Other: _____

Patient/Guardian Signature: _____

Date: _____

Are you under a physician's care? What for?

General Physician's Name: _____ Ph # _____

Are you taking any medications? YES / NO

If Yes, please list all:

Pharmacy Name _____ Ph # _____

Women – Do you suspect that you are pregnant? Yes No Due date: _____
Are you taking birth control pills? Yes No Are you nursing? Yes No

DENTAL HISTORY

Please check any of the following problems that apply to you.

- Sensitivity (Hot, Cold, Sweet)
Where? Upper Right or Left
Lower Right or Left
- Headaches, ear aches, neck pain
- Do you snore or suffer from a sleep disorder?

- Teeth or fillings breaking
- Grinding or clenching
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

Do you have or have you had any of the following?

- Dentures Partials Implants
- Braces Periodontal(Gum) treatments

Please share the following dates:

Your last cleaning _____ / _____
Your last oral cancer screening _____ / _____
Your last complete set of X-rays _____ / _____

Name of Previous Dentist _____
City _____ State _____
Phone # _____
Why did you leave your previous dentist?

If you could whiten your teeth for a cost anyone could afford, would you do it? Yes/No

Do you smoke or use chewing tobacco?
How much? _____ For how long? _____
Do you drink alcohol? YES/NO
How often? None/ Social/ Daily

- If I could change my smile, I would:
- Make them whiter
 - Make them straighter
 - Close spaces
 - Replace metal fillings with tooth colored ones
 - Repair chipped teeth
 - Replace missing teeth
 - Replace old crowns that don't match
 - Have a smile makeover

On a scale of 1-10, with 10 being the highest:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10
What is the most important thing to you about your dental visit today? _____

FINANCIAL POLICY

Payment Options:

For your convenience we accept cash, checks, debit cards, Visa, MasterCard and American Express for payment.

Patients without insurance are expected to pay in full at the time of service.

Patient's with insurance are expected to pay all deductibles and percentages not paid by the insurance company at the time of service. The patient is financially responsible to pay the full fee, regardless of insurance payment.

Payment Plans: *Care Credit* offers interest free payment plans for 6 or 12 months. *ChaseHealthAdvance* offers 18 or 24 month interest free payment plans for larger treatment needs. See contracts for details.

Please Note:

- Balances older than 90 days are subject to interest charges of 1.5% per month (18% annually).
- Returned checks are subject to a \$25.00 charge.
- 24 hours notice is required to change any appointment. We reserve the right to charge \$50.00 if notice is not given.

I, _____, *have read, understood
and agree to abide by the terms above.*

Date: ____/____/____ Patient's Signature: _____

Parent or Responsible Party: _____ Relationship to Patient: _____

Alina de la Torre, D.M.D.
10830 Sheldon Road - Tampa FL 33626 - 813.792.9400

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

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: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. 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:

Contact Person: The Office of Alina de la Torre, D.M.D., P.A.

Telephone: 813-792-9400 Fax: 813-792-5880

E-mail: _____

Address: 10830 Sheldon Road Tampa FL 33626

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 health 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: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

LIMITED DENTAL WARRANTY

Our practice is proud of the dentistry that we provide for you and your family. The long-term success of the dental treatment we provide for you depends upon your commitment to home care of your teeth and gums, regular professional examinations and cleanings. Individuals vary in how often cleanings are needed. **Cleanings may be recommended every 3, 4 or 6 months, depending upon your individual oral health needs.**

DENTAL SEALANTS:

Sealants are plastic coatings placed on the chewing surface of the teeth to help prevent decay in the pits, fissures and grooves of the teeth. Floss and the use of Fluoride will help prevent decay between the teeth. We will replace sealants for a period of 5 years after initial placement by our office. **You must keep the prescribed regular exam and cleaning appointments or this warranty is null and void (minimum every 6 months).**

FILLINGS:

If a filling restoration is the recommended treatment of choice, we will replace or repair it in the event of failure for a period of 3 years. If the tooth breaks and requires a crown, we will credit the cost of the filling towards the crown. **You must keep the prescribed regular exam and cleaning appointments or this warranty is null and void (minimum every 6 months).**

ROOT CANALS:

Root canal treatment is about 96% successful. They do occasionally fail. If you lose your tooth within 3 years due to failure of the root canal, we will refund the root canal fee, or apply it as a credit towards a replacement tooth. **You must keep the prescribed regular exam and cleaning appointments or this warranty is null and void.**

CROWNS, BRIDGES, INLAYS AND ONLAYS:

We will warranty these most comprehensive procedures for a full 5 years. We will replace or repair them at no charge during this 5-year period if they break, are lost or decay with normal use. This does not include accidents that could break normal healthy teeth. **You must keep the prescribed regular exam and cleaning appointments or this warranty is null and void.**

NOTE: The primary key to long term success is good nutritional habits, proper home care: brushing, flossing and using prescribed products. The second key to success is regular professional cleanings, radiographs (x-rays) and examinations. This warranty does not apply if you have chosen an alternate treatment plan to the one that was recommended. This warranty also does not cover accidents that cause damage to the teeth or dental prosthesis.

Date: ____/____/____ Patient's Signature: _____

Parent or Responsible Party: _____ Relationship to Patient: _____

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ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to provide you the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, or Visa. We will be happy to process your insurance claim for you, however, deductibles and co-insurance amounts are due at each visit.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of "U.C.R." is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.

This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.