

W E L C O M E

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____

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

Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____
Email _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patient) _____ Home Phone _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____

Insurance Company _____ Phone _____
Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address (if different from patient) _____ Soc. Sec. # _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____
Business Email _____

Insurance Company _____ Phone _____
Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |
- How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) yes or no whether you have had any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | | |

Is patient currently taking any medications? If yes, list all:

Does patient have drug allergies? If yes, list all:

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.



David De La Garza Jr., DDS

Pyramid Plaza
7434 Louis Pasteur, Suite 236
San Antonio, TX 78229
(210) 681-1113

Consent To Perform Dentistry

1. I hereby authorize and direct Dr. David De La Garza Jr. DDS and/or dental auxiliaries of his choice, to perform the following dental treatment or oral surgery procedures including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

- A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
- B. Application of plastic "sealants" to the grooves of the teeth
- C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns)
- D. Replacement of missing teeth with dental prostheses. (bridges, partial dentures, full dentures)
- E. Removal (extraction) of one or more teeth
- F. Treatment of diseased or injured oral tissues (hard/and/or soft)
- G. Use of sedative drugs to control apprehension and/or disruptive behavior.
- H. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
- I. Use of general anesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand.

3. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

4. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to the medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks.

5. I also authorize Dr. David De La Garza Jr. DDS to use radiographs, photographs, other diagnostic material and treatment records for purpose of teaching, research, and scientific publications.

6. I will be advised that the success of dental treatment to be provided will require that the patient and the parents follow post-operative/post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative/post care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.

7. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to question which my arise during and after the course of treatment.

Patient's Name: _____

Name of Parent/Guardian: _____ **Relationship:** _____

Signature: _____ **Date:** _____
(Patient/ Parent or Guardian)



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Financial Policy

PAYMENT IS DUE THE DAY SERVICES ARE RENDERED

For your convenience we accept cash, check, Visa, Mastercard, American Express, Discover, Flex Spending Card, and CareCredit (with approved credit).

Insurance

Insurance benefits are determined by your employer, and not the dentist. Any deductible or estimated co-payment "patient portion" is due the time of treatment. Insurance is not a guarantee of payment: dental insurance helps deter your out of pocket expense and DOES NOT cover all services cost. Your insurance policy is a contract between you and your insurer. As a courtesy to our patients, we submit your dental claims. Any fees given by our dental office are strictly an estimate. The insurance company will determine payment and any remaining balance will be the patient's responsibility. Any unpaid balances can be sent to collections at any time.

Missed Appointment

Appointments are reserved exclusively for you. We reserve the right to charge and collect a \$25.00 fee for broken appointment without a 24 hour cancellation notice. Too many missed appointments may result in dismissal from our practice.

Returned Check

Checks that are returned will be subjected to a \$25.00 charge. We reserve the right to send any NSF to the District Attorney's office.

Patient's Name: _____

Name of Parent/Guardian: _____ **Relationship:** _____

Signature: _____ **Date:** _____
(Patient/ Parent or Guardian)



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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically (emailing), on paper, fax, 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. We have prepared this explanation of how we are required to maintain the privacy of your health information and we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure the dentist has the necessary information to diagnose or treat you.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

Health care 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. We may also create and distribute de-identified health information by removing all references to individually identifiable information. 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. We may also call you by name in the waiting room when your dentist is ready to see you. We may also disclose information for a Disaster Relief and Public Benefit.

Other permitted and required 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 right to request restrictions on certain uses and disclosures of 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.

You have the right to inspect, copy, amend your protected health information.

You have the right to receive an accounting of disclosures of protected health information and to obtain a paper copy of this notice from us upon request. You have recourse if you feel that your privacy protections have been violated.

You have the right to file a written complaint to the Department of Health and Human Services. We will not retaliate against you filing a complaint. Any questions or objections to this policy, please speak with our HIPAA Compliance Officer.

This notice is in effective April 14, 2003 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 and make the new notice provisions effective for all protected health information that we maintain.



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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received and reviewed a copy of Dr. David De La Garza Jr., D.D.S Notice of Privacy Practices.

Signature: _____ **Date:** _____
(Patient/ Parent or Guardian)



For Office Staff Only

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

- Refusal to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other _____