PATIENT REGISTRATION

Patient Information

Patient First Name: _____ **Last Name:** _____ **Middle Initial:**____

Patient is: Policy Holder Spouse Child Other: _____ Prefered Name: _____

Birth Date:_____ Age _____ SSN: _____ Drivers License:_____

Address: _____

City, State, Zip: _____

Male _____ Female _____ Marital Status: Married Single Divorced Seperated Widowed

Employement Status: Full Time Part Time Retired None Student Status: Full Time Part Time

Responsible Party (If someone other than patient)

First Name: _____ Last Name: _____ Middle Initial:_____

Birth Date:_____ SSN: _____ Drivers License:_____

Address: _____

City, State, Zip: _____

Primary Insurance Information

Name of insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company:_____

Address: _____ Address: _____

City, State, Zip _____ City, State, Zip _____

Secondary Insurance Information

Name of insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company:_____

Address: _____ Address: _____

City, State, Zip _____ City, State, Zip _____

Oasis Dental
Associates, P.A.

Patient Authorization for PHONE and EMAILS

Our office policy has changed, in order to comply with HIPAA regulations. Effective immediately, the phone numbers and email you provide on this form will be used when contacting you (via hca@smile.ms). This also authorizes us to leave messages via email, text or email pertaining to your appointment, preauthorization etc.

Home : ( ) _____

Work: ( ) _____

Cell: ( ) _____

Email: _____@_____

If you have moved or have an address change, please provide it in the space provided below:

Address _____

City _____ State_____ Zip_____

Patient Name: _____

Patient Signature: X _____ Date _____

Alex E. Aleman, D.M.D.
10796 Pines Boulevard Suite #203 • Pembroke Pines, Florida 33026
Office: (954) 499-1599 • Fax: (954) 499-5799

Oasis Dental Associates, P.A.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN X _____ DATE _____

Oasis Dental Associates, P.A.

Appointment Policy

1. Please be advised that our office requires at least 24 hours notice for appointment cancellation to prevent incurring a $ 25.00 charge on your account. Thank you for your understanding in this matter.

2. Our office requires a deposit before scheduling appointments. Deposits are half (1/2) of the treatment being scheduled.

Patients Signature: X_____ Date: _____

1. Por favor le hacemos saber que nuestra oficina require se nos informe al menos 24 horas antes de cancelar una cita para evitar un cargo de $25.00 en su cuenta. Gracias por su cooperacion.

2. Nuestra oficina require un deposit antes de hacer una cita. El deposito sera la mitad del tratamiento que usted escoja para comensar en su proxima cita.

Firma del Paciente: _____ Fecha: _____

Insurance Policy Disclaimer

Please be aware that all pre-estimates, pre-authorizations and or verification of benefits that may be available under your insurance plan are **NOT** a guarantee of payment until claim is presented and processed. Patient is responsible for any claims denied by the insurance company. Outstanding balances are due within 30 days of denial.

Patients Signature: X_____ Date: _____

Por favor tengan en cuenta que todos los beneficios que puedan estar disponibles bajo su plan de seguro **NO** son una garantia de pago hasta que se presente la reclamacion y sea procesada por la compania de seguro. El paciente sera responsable de cualquier reclamacion denegada por su seguro. Los saldos pendientes son debidos en el plazo de 30 dias de la negacion.

Firma del Paciente: _____ Fecha: _____

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HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement;
- this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness X.....

Printed Name of Individual or Legal Representative .....

Witness.....

Date: .....

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

_____

_____

_____

_____ _____

HIPAA Officer Date

List family Members we can speak to other than yourself.

Office Procedures

1. I authorize the following person/persons to be my personal represenative, which means the doctor and staff may speak freely to the named personal represenative regarding all my Protected Health Information, Medical and treatment matters and billing.

Name of Authorized Person/Relationship

_____ _____

_____ _____

_____ _____

Patient's Signature X _____ **Date:** _____

2. I authorize the following named person/persons to authorize medical treatment on my named children. The doctor and staff may speak freely regarding my child/children's protected health information, medical treatment matters and billing. I understand that I am still responsible for the billing.

Name of Authorized Person/ Relationship	**Children's Name**
_____	_____
_____	_____
_____	_____

3. I, _____, authorize this facility to examine and provide medical treatment. I assume full resposibility for any balance due. I authorize my insurance company to pay by check made out directly to this facility. I authorize this facility to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit. I understand it is my responsibilty to know all the rules and restrictions of my insurance policy, to know which hospitals emergency rooms, laboratories, and facilities procedure to share Protected Health Information with labs, xrays, consulting physician, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary information Protected Health Information for each transaction.

4. Our office is HIPAA- compliant and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect your Patient Health Information.

However, our office was designed before the HIPAA Law so please be respectful of other patients' privacy.

I, _____, agree to all the above procedures of this facility, and give my authorizaton to all of the above procedures.

Patient Signature X _____ **Date** _____

Oasis Dental
Associates, P.A.

Personal Representative Authorization For
Medical Release Form

I authorize this facility to speak to the following **family members** or **my personal representative** regarding:

- All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctors notes and any other non medical information n my file.

Only the following types of information:

_____

_____

The above medical information shall only be released to the following persons:
(Please list any Family members or personal representative other than yourself)

Family Member/ Personal Representative	**Relationship**
_____	_____
_____	_____
_____	_____

List Family Members we can speak to other than yourself.

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one)

- Until revoked in writing.
- Until _____, 20 ___

I know that I am entitled to receive a copy of this agreement.

Name _____

Signature X _____

Signed this _____ day of _____, 20 ____

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