Patient Information

Name ____ Soc. Sec. #_________________________

Address ____________________________________ Email ______________________________

City ____ State__________ Zip__________________

Sex: ( ) M ( ) F Birthdate ______________ ( ) Single ( ) Married ( ) Divorced ( ) Other

Home phone ____________________________ Mobile phone _______________________

Patient employed by _____________________________________ Occupation __________________

Business Address ___________________________________ Business Phone ___________________

Whom may we thank for referring you? ____

In case of emergency who should be notified? _________________________Phone_______________

Primary Insurance

Person Responsible for the Account____

Relation to Patient____ Birth date ___________________

S.S #_______________________ Address (if different from patient) _____________________________

Phone -_____________________ City _________________________ State _______ Zip __________

Business Address _____________________________________ Business Phone __________________

Insurance Company ___________________________________ Group #_______________________

I.D. #________________________________ Subscriber S.S. #______________________________

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with above mentioned insurance company and assign directly to Dr. Julio A. Rodriguez all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

________________________________ ______________________________ _____________

Responsible Party Signature Relationship to patient Date

Date:_________________ | **Name:_________________**

Dental History (Confidential)

Reason for Today's visit____

Former Dentist____

Date of last dental care_______________ Date of last dental x-ray_____________

Circle yes or no if you have had problems with any of the following:

Bad breath	Y	N	Grinding teeth	Y	N
Bleeding gums	Y	N	Loose teeth or broken fillings	Y	N
Clicking or popping of jaw	Y	N	Periodontal treatment	Y	N
Food collection between teeth	Y	N	Sensitivity to hot/cold or sweet	Y	N
Sores or growths in your mouth	Y	N			

How often do you floss?____________ How often do you brush?____________

Medical History

- Have you been examined or treated by a physician in the last year?

  ❒ YES ❒NO

  If yes, for what reason? ____

- Have you had any type of surgery or outpatient procedure in the past year?

  ❒YES ❒NO

  If yes, for what reason? ____

  Type of anesthesia: ______________________ Complications:________________

- Have you been to the Emergency Room or Urgent Care Facility in the past year?

  ❒ YES ❒NO

  If yes, for what reason ____

- Have you been hospitalized in the past year?

  ❒ YES ❒NO

  If yes, for what reason ____

Physician's Name_________________________ Date of last visit_______________________

- Have you ever had a blood transfusion?

  ❒ YES ❒NO

  If yes, When? ____

- Have you had any unusual bleeding in the past year?

  ❒ YES ❒ NO

  If yes, please describe:____

(Women)

Are you pregnant?❒YES❒NO Nursing? ❒ YES ❒ NO Taking birth control pills? ❒ YES ❒ NO

Do you smoke? ❒ YES ❒ NO How much?________

Do you drink Alcohol? ❒ YES ❒ NO How much?________

Date:_________________ Name:_________________

Medical History continued….

Please Circle Yes or No

Aids	Y	N	Hepatitis	Y	N	Skin Rash	Y	N
Anemia	Y	N	Headaches	Y	N	Stroke	Y	N
Arthritis, Rheumatism	Y	N	Heart Murmur	Y	N	Swelling of feet or ankles	Y	N
Artificial Heart Valves	Y	N	Heart Problems	Y	N	Thyroid Problems	Y	N
Artificial Joints	Y	N	Hemophilia	Y	N	Tonsillitis	Y	N
Asthma Back Problems	Y	N	High Blood Pressure	Y	N	Tuberculosis	Y	N
Back Problems	Y	N	HIV Positive	Y	N	Ulcer	Y	N
Blood Disease	Y	N	Jaw Pain	Y	N	Venereal Disease	Y	N
Cancer	Y	N	Kidney Disease	Y	N			
Chemical Dependency	Y	N	Liver Disease	Y	N			
Chemotherapy	Y	N	Mitral Valve Prolapse	Y	N			
Circulatory Problems	Y	N	Nervous Problems	Y	N			
Cortisone Treatments	Y	N	Pacemaker	Y	N			
Cough, persistent	Y	N	Psychiatric Care	Y	N			
Cough up blood	Y	N	Radiation Treatment	Y	N			
Diabetes	Y	N	Respiratory Disease	Y	N			
Epilepsy	Y	N	Rheumatic Fever	Y	N			
Fainting	Y	N	Scarlet Fever	Y	N			
Glaucoma	Y	N	Shortness of Breath	Y	N			

List any medications you are currently taking:

Medication	Dosage	Frequency	Reason
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

In the past week have you taken any recreational or medicinal drugs not listed above?

❒ YES ❒NO

If yes then what? ____

Please Select any Allergies you may have:

☐Aspirin ☐Barbiturates (sleeping pills) ☐Codeine ☐Local Anesthetic ☐Penicillin ☐Sulfa
☐Other ____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date___________________ **Signature**____

Patient Acknowledgement of Receipt of the Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. I hereby consent to the use and disclosure of my health information for the purposes and the activities under the federal privacy law. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the office.

______________________________ ____________________
Patient's Name (Please print) Date

____
Signature (if minor Parent or Guardian)

____
Patient's Legal Representative (if applicable)

____
Signature of Legal Representative

Dental Arts of Sunset
Office Policies 2017

1) All fees will be explained to patient along with the proposed treatment plan before any services are commenced. Fees are to be paid in full at the time of service.

Initial ______

2) Sometimes during treatment the plan may have to be modified at the Doctors discretion to account for any complications that may have been unforeseeable. Procedures may have to be added or omitted. No new procedures will be commenced without disclosing any additional fees to patient.

Initial ______

3) Accounts 30 days past due will incur finance charge of 1.5% per month. Accounts 60 days past due will be turned over to either collection agency or attorney.

Initial ______

4) In the event that collection or court proceedings are necessary to collect sums due and owing to us, the patient agrees to be fully responsible for the payment of all attorneys' fees and costs in connection with the proceedings (due to returned checks or otherwise).

Initial ______

5) Your appointment time is RESERVED exclusively for YOU. We NEVER double book patients. This allows us to run on time and more importantly it allows YOU to run on time without annoying waits. In order to accomplish this we cannot tolerate broken appointments. If you have an appointment with us and your plans change we require 48 hours advance notice, or as soon as possible, in case of an emergency so your appointment will not be considered "BROKEN". Any patient who breaks and appointment will be required to give a $50/hour deposit in exchange for a future appointment. Deposit will be forfeited in the event the appointment is broken again.

Initial ______

6) **Patients with insurance**. We will be happy to file on your behalf. We will also try to estimate what they may cover. Our estimates are based on a telephone conversation with an operator at your insurance company. This is NOT A GUARANTEE OF BENEFITS and we cannot be responsible for the terms/limitations and exclusion of your particular plan. We encourage you to become familiar with the fine print of your plan. Patients will be required to pay in full any claims not paid by the insurance carrier within 30 days and any remaining balance if the insurance pays less than what was estimated.

Initial ______

7) This agreement, when signed by both parties, is a legal, binding contract and supersedes all other agreements, oral, written, past or present.

Initial ______

______________________________ ______________________________
Patient or Guardian Office Representative

______________________________ ______________________________
Date Date

Payment Options

1. Cash
2. Credit Card- Visa, Master Card, American Express, Discover Card
3. Personal Check: Processed through TeleCheck
4. DEBIT/ATM Card
5. CareCredit or Lending Club: Third party financing Company

I have Read and understand the payment options of this office.

____

Patient or Guardian Signature

____

Date