PERIO ORTHO **ADULT PATIENT INFORMATION** **INS _____ NO INS_____**
WELCOME FD Staff Initials _____

Date Jul 27, 2018
Patient's name _____ DOB_____ **Gender: F M**
Last First Middle
Adress___,
Street City Zip
Cell #___ Otherl #_____ **Email Address:**_____.

Marital Status: Single__ Married__ Widowed__Separated__Divorced__.

Employer_____,Occupation_____,No. years employed_____.

How did you hear about us?_____,Reason for today's dental_____.

EMERGENCY CONTRACT (Specify someone who does not live in your household)

Name _____ Relationship _____Phone # _____

DENTAL INSURANCE INFORMATION

Policy Holder _____ DOB_____ Member ID or SSN# _____
Insured'sName_____ Employer Company Name _____
Insurance Co. Address_____ Phone No. _____ Group No._____

Is patient covered by additional insurance? Yes_____ No_____

MEDICAL HISTORY

Medication

List any medications you are correctly taking:
_____
_____
_____

Allergies

Aspirin	Local Anesthetic	Barbiturates (sleeping pills)
Penicillin	Codeine	Sulfa
Lodine	Latex	

Other _____

Physician _____Date of Last Visit_____Phone_____

Please circle Yes or No (If Yes, please fill in details)

Yes No Have you ever used a bisphosphonate medication? Like: Fosamax, Actonel, Atelvia, Didronel, Boniva
Yes No Do you take any medication for anticoagulant or antiplatelet (Aspirin,coumadin, Rivaroxaban, Dabigatran, Heparin
Yes No Have you ever taken any of the group of drugs collectively referred to as "Fen-phen?" These include combinations of lonimin, Adipex, Fastin,(brand names of phentermine), Pondimin (fenfluramine) and Redux
Yes No Do you smoked or chewed tobacco

Female Patients only:
Yes No Are you pregnant?
Yes No Are you nursing?

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis, Rheumatism	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Artificial Heart Valves	Artificial Joints	Chemotherapy
Heart Murmur	Nervous Disorders	Tumor or Cancer	Emphysema
Fainting or Dizziness	Glaucoma	Rheumatic Fever	Scarlet Fever
Kidney Disease	Liver Disease	Low blood pressure	Mitral Valve Prolapse
Nervous Problems	Pacemaker	Bleeding Abnormally, with extractions or surgery	Thyroid Problems
Tumor or growth on head or neck	Cough,persistent or bloody diabetes		

Are there any medical conditions we have not discussed that you feel we should be aware of?_____
_____

DENTAL HISTORY

General Dentist_____Date of last visit_____Phone # _____

What concerns you most about your teeth?_____

NEXT PAGE

BENEFITS

Benefits of Orthodontics and Periodontics: Aesthetics, Health, and Function. These dental services provide an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases of orthodontics. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize _Dr. Cruz__ to perform a complete orthodontic evaluation.

Signature:_____ Date:_____

Dr Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information

As a patient you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. Notice of Privacy Practice contains information about how we will insure that your information remains private.

PLEASE LIST ALL TELEPHONE NUMBERS WHERE WE MAY CONTACT YOU:

_____

_____

PLEASE LIST THE NAME OF ALL PEOPLE(SPOUSE, PARENTS, GRANDPARENTS, ETC) YOU AUTHORIZE US TO RELEASE YOUR HEALTH INFORMATION TO, INCLUDING COPIES OF YOUR RECORDS IF NEEDED:_____

_____

Acknowledgement of Notice of Privacy Practice

I hereby acknowledge that I have reviewed this practice's Notice of Privacy Practice. If further understand that the practice will offer me updates to this Notice of Privacy Practice. Should it be amended, modified or change in any way i will receive a copy.

_____ _____

Print Name of Patient Signature of Patient/Parent/Legal Guardian

sonrisas dental center
orthodontics and periodontics

FOR OFFICE USE ONLY

Yes No Have you ever seen an orthodontist?_____
Yes No Are you presently in any dental pain?_____
Yes No Is any part of your mouth sensitive to pressure?_____
Yes No Do your gums bleed when you brush?_____
Yes No Are you aware of your jaw clicking or popping?_____
Coments: _____

Staff Initials _____

Patient Name: **Date: Jul 27, 2018**

Sonrisas Dental Center is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

Cancellation/Missed Appointments

- In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 48 hours in advance. Calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

- A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". There will be a fee of $25.00 for regular appointments and $50.00 for any dental cleanings or surgerys. Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed a cancellation fee.
- Please be sure to arrive at least 15 minutes early
- In consideration of other patients if you arrive more than 5 minutes late for your or your child's appointment you may be asked to reschedule.

Please be aware that some appointments will be during WORK or SCHOOL hours

Thank you for understanding and please let us know if you have any questions or concerns.

Responsible Party Initials _____

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization: I authorize the use and disclosure of my name, photo- graphic/video images, and/or testimonial for reasearch, statistics and marketing purposes by Sonrisas Dental Center. I understand that information disclosed pursuant to this authorization may be subject to re disclosure and may no longer be protected by HIPAA privacy regulations.
Purpose: The photographic/video images, and/or testimonial will be used for: *Social Media and/or Advertising*
Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.
No Treatment Conditions: I understand that the practice cannot condition treatment on whether or not I sign this authorization.

☐ I CONSENT THE USE OF RECORDS AND PICTURES

☐ I REFUSE THE USE OF RECORDS AND PICTURES

Patient/Parent or Legal Guardian Name:

Signature: _____ Date: _____