DENTAL & ORTHODONTICS

YOUR MOST COMPREHENSIVE & CONVENIENT DENTAL SERVICE

PATIENT INFORMATION FORM

Patient Information

Last Name ______________________ **First** _________________________**Middle Initial** ______________

Name of Guardian if patient is a minor:____

Circle one: □ Dr. □ Mr. □ Mrs. □ Ms. **Gender**: □ male □ female

Birth Date: ____/_____/____ SSN#:_________-__________-_________ DL# __ __ __ __ __ __ __ __

Address: ____

City/State/Zip____

Email Address: ____

Home Telephone #______________________________ Work #_______________________ext. _________

Fax #: ________________________Pager #: _______________________Cell #: _____________________

Employer:_________________________ Position/Title_____________________ # of yrs_____________

Business Address:____

Spouse's Name _____________________________________ Work # : ____________________ext: _____

In case of Emergency contact: ______________________Relation:_________________#:_________________

Dental History

Name of Previous Dentist: ____________________________ Phone#_______________

Date of last dental visit: ____________________ Date of last cleaning: ___________Date of last X-Ray_______

Dental Insurance

Insurance Co. Name:____ Group#: _____________________

Customer Service 1 800 _ _ _ -_ _ _ _ ID Number: _____________________________

Who is the insured member in you family? □ Yourself □ Spouse □ Other

Insured's DOB ________________ Insured's SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___

Insured's Employer: ____ Wk#: __________________

Dental Claim Agreements

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted under applicable law, I authorize release of any information relating to any dental claims. I hereby authorize payment of the dental benefits otherwise payable to me directly 101 Dental and orthodontics.

____

Patient/Parent Signature **Date**

FOR FASTER SERVICE PLEASE HAVE YOUR DRIVER LICENSE AND DENTAL INSURANCE CARD AVAIBLE.

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Medical History

Are you currently under the care of a physician?

Physicians Name: ____Phone: ___________________________

Date and reason of Last exam: ____

Do you have a current medical problem? Y/N Explain?

____

____

____

Please list any prescription/over-the-counter drugs you are taking:

Name of Medication ______________________________ dosage ________________ for _____________________

Name of Medication ______________________________ dosage ________________ for _____________________

Name of Medication ______________________________ dosage ________________ for _____________________

Name of Medication ______________________________ dosage ________________ for _____________________

Medical History

Yes	No	Condition
☐	☐	ADD/ADHD – Attention Deficit Disorder/ Attention Hyperactivity Disorder
☐	☐	AIDS/HIV+
☐	☐	Anemia
☐	☐	Allergies
☐	☐	Asthma
☐	☐	Autism
☐	☐	Behavioral Problems
☐	☐	Birth defects
☐	☐	Blood Transfusions
☐	☐	Bone or Joint Problems
☐	☐	Brain Injury
☐	☐	Cerebral Palsy
☐	☐	Cancer/Tumor
☐	☐	Chemical Dependency
☐	☐	Chemotherapy/Radiation
☐	☐	Chicken Pox
☐	☐	Child Abuse
☐	☐	Cleft Palate/Lip
☐	☐	Cold Sore/Canker Sores
☐	☐	Developmentally Delayed: Age level is___
☐	☐	Diabetes
☐	☐	Earaches/Ear Infections
☐	☐	Epilepsy/Seizure Disorder
☐	☐	Eye Conditions
☐	☐	Females: Are you pregnant?

Medical History

Yes	No	Condition
☐	☐	Hearing Impairment
☐	☐	Heart Disease
☐	☐	Heart Defect
☐	☐	Heart Murmur
☐	☐	Hemophilia
☐	☐	Hepatitis/Liver Disease
☐	☐	High Blood pressure
☐	☐	Hospital Stay/Operation **(Please explain)**
☐	☐	Injury to Front Teeth
☐	☐	Kidney Disease
☐	☐	Low Blood Pressure
☐	☐	Lupus
☐	☐	Mentally Handicapped
☐	☐	Metallic Implant, Shunts, Pins/Rods
☐	☐	Mononucleosis
☐	☐	Premature Birth
☐	☐	Prolonged Bleeding When Cut
☐	☐	Psychiatric Care
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Sickle Cell Disease
☐	☐	Sore Throats
☐	☐	Speech Impairment
☐	☐	Thyroid Disease
☐	☐	Tonsillitis
☐	☐	Transplant (Please specify organ)

Name of Medication ______________________________ dosage ________________ for _____________________

Please list any other medical condition(s) and/ or serious illnesses that we should be aware of:

____

____

Are you allergic to or do you suffer ill effects from any of the following?

____ Penicillin ____ Codeine ____ Dental Anesthesia ____ Aspirin ____ Household Bleach ____ Nickel _______________

____ Aspirin ____ Sulfa Drugs ____ Latex ____ Aspirin ____ Epinephrine ____ Other:__________________________________

The information provided today is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I understand that this office will assist me in getting my insurance reimbursement but I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment unless prior arrangements have been approved.

____

Patient/Parent Signature **Date**

____

Doctor Signature **Date**

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HIPAA CONSENT FORM

Patient's Name: ___________________________
(*Nombre del Paciente)*

Date of Birth: _____________________________
(Fecha de Nacimiento)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

*** Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment)**
*** Obtaining payment from third party payers (e.g. my insurance company)**
*** The day-to-day healthcare operations of your practice**

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. In understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Patient/Parent/Guardian Signature: ______________________ Date: ___________

FORMA DE CONSENTIMIENTO HIPAA

Yo entiendo que tengo ciertos derechos a la intimidad con respecto a mi salud. Estos derechos son dados a mi bajo la Transportabilidad de Seguro de Enfermedad y Acto de Responsabilidad (HIPAA) de 1996. Entiendo que firmando este consentimiento le autorizo utilizar y a divulgar mi informacion protegida de salud para realizar:

*** Tratamiento (incluyendo directo y indirecto por otros proveedores de asistencia sanitaria implicados en mi tratamiento)**
*** Obteniendo pagos de pagadores de terceros(e.g. mi compania de seguros)**
*** Las operaciones diarias de la asistencia de su practica.**

He sido informado tambien de, y dado el derecho de revisar y asegurar una copia de la Nota de Practicas de Intimidad, que contiene una descripcion mas completa de los usos y revelaciones de mi informacion, y bajo mi derecho de HIPAA. En ella entiendo que usted merece el derecho de cambiar los terminos de este aviso de vez en cuando y que puedo contactar esta practica para obtener la copia mas actual de este aviso.

Yo entiendo que tengo el derecho de solicitar que las restricciones en como mi informacion protegida de salud se utiliza y es revelada para llevar a cabo tratamiento, pago, y operaciones del healthcare, pero eso no le requiere estar acuerdo con estas restricciones solicitadas. Sin embargo, ningun uso de la revelacion que ocurrio antes de la fecha que yo revoco este consentimiento no se afecta.

Firma del Paciente/Pariente: _______________________________ Fecha: ______________
Médico de la firma: ______________________________________Fecha:_______________

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101 Dental & Orthodontics

FACTS YOU SHOULD KNOW ABOUT DENTAL INSURANCE

Print Patient Name:___________________________ DOB:________________

Your dental benefit program is a contract between you, your employer, and the insurance provider company.
WE ARE NOT PART OF THAT CONTRACT.

Dental insurance is not meant to be pay-all, only to be an aid.

Our fees are generally, but not necessarily, covered in full by the maximum allowance determined by your carrier. Many plans tell their insured that they will be covered "up to 80% or up to 100%" but do not clearly specify the plans fee scheduled allowance, annual maximums or limitations. We have found that most plans cover about "35% to 50%" on major services (crowns, bridges, and root canals) based on the plan's pre-established maximum fee allowance which varies from carrier to carrier.

It has been the experience of many dentists that insurance companies occasionally tell their insured that "the fees charged are above usual and customary rate", rather than saying, "Their benefits are low".

Insurance carriers do not cover many routine dental services. (For example, nitrous-oxide-laughing gas)

YOU THE PATIENT, ARE ULTIMATELY RESPONSIBLE TO US FOR ALL FEES FOR SERVICES RENDERED. If your insurance company has not paid on your claim within 30 days of services rendered, then it is **YOUR RESPONSIBILITY** to check and see why the claim has not been paid and your balance is due in full. Our office staff will be glad to assist you in any way they can regarding your insurance claim payments.

Please do not hesitate to ask any questions about our office policy. We want you to be comfortable in dealing with these matters and we urge to consult us regarding our services and/or fees. We are here to answer any question you have about your insurance or any dental treatments.

I understand the office policy of 101 Dental & Orthodontics regarding my insurance and my responsibility of services rendered.

____

Patient/Guardian Sign **Date**