Welcome

In order to help you reach and maintain maximum oral health, it is very important that we know all medical, dental and personal identifying information about you. Please fill out every section on this or any other form and provide us with the requested information. The better we communicate, the better we can care for you.

About You

Name: _____
LAST FIRST MI MR MRS MS DR

**E-mail Address:* _____

Preferred Nickname: _____ ☐ Male ☐ Female

DOB: ____/____/____ Age: ____ SS#: _____-____-_____

Address: _____
APT/CONDO #

_____
CITY ST ZIP

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Life Partner ☐ Engaged ☐ Minor

If patient is a minor, give parents or guardian's name & put their info in "spouse" area:

_____

Occupation: _____ How long there? _____

Employer: _____

Spouse's Name: _____

Spouse's Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you?: _____

Phone Numbers

Cell Phone: _____

Home Phone: _____

Work: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relation: _____

Home/Cell Phone: _____

Work Phone: _____

PHARMACY INFORMATION:

_____

_____

Dental Insurance

Primary PPO Dental Insurance

Insurance Company: _____

Claims address: _____

_____

Insurance Co. Phone #: (____)_____

Policy ID # _____

Group # _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____/_____/_____

Insured's SS #: _____

Insured's Employer:_____

DIAZSMILE
PUTTING A SMILE BACK IN DENTISTRY

Assignment & Release

I certify that, if applicable, I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I 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. If I do not have insurance benefits, I again acknowledge that I am solely responsible for all charges incurred and will pay for services in full when scheduling appointments and or upon treatment commencement.

X_____

RESPONSIBLE PARTY SIGNATURE

_____ _____

RELATIONSHIP TO MINOR (IF APPLICABLE) DATE

Medical History Please complete all fields

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If so, please explain:

_____

_____

Have you had any recent surgeries:

_____

Have you taken oral or intravenous (I.V.) Bisphosphonates, such as Boniva or Fosamax, if so please list:_____

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

List: _____

Are you allergic to any of the following?

Latex	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No
Penicillin	☐ Yes ☐ No	Codeine	☐ Yes ☐ No
Dental Anesthetic	☐ Yes ☐ No	Jewelry/Metals	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Erythromycin	☐ Yes ☐ No

Other ☐ Yes ☐ No _____

For Women:

Taking birth control pills? ☐ Yes ☐ No

Are you pregnant? How many weeks? _____ ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Do you have or have you ever had any of the following disease or medical problems?

Heart Murmur	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
HIV+/AIDS	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No
Tumors/Growths	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Tobacco/Smoker	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Alcohol/Drug Abuse	☐ Yes	☐ No
Alzheimer's disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Artificial Bones/Joints/Valves	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No

Difficulty Breathing	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Herpes	☐ Yes	☐ No

Hospitalized, if so reason_____

_____

Kidney Problems	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Nervous/Anxious	☐ Yes	☐ No
Psychiatric Concerns	☐ Yes	☐ No
Rheumatic /Scarlet Fever	☐ Yes	☐ No
Seizures/Epilepsy	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
HPV- Human Papillomavirus	☐ Yes	☐ No

Certification: I certify that the answers given are correct to the best of my knowledge.

Printed Name : _____ Date of birth :_____/_____/_____

Address: _____

Cell phone : (_____) _____-_____ Email: _____

Signature: X_____ Date: _____

To Our Appreciated Patient,

It is our desire to constantly improve services and quality of care for you so that you can regain and or maintain your dental health as quickly and as efficiently as possible. Our commitment is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our team and your great experience. Therefore, the following must be agreed upon:

1. Insurance: Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance, it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or wellbeing; WE ARE! As a courtesy, we will provide you with an estimate of benefits; however, you are **100%** financially responsible for any treatment performed.

2. Your benefits are a contract between you and your insurance company. As a reminder, we cannot be responsible for what your insurance will or will not cover. We do our best to estimate you're out of pocket as accurately as possible, but you hold the insurance, so you are ultimately responsible for all charges.

3. Timeliness is required. We will see you on time and get you out on time unless there is an unforeseen emergency. We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment and a missed appointment fee will apply. Cleanliness and infection control are of the utmost importance. We have the latest sterilization technology and disinfect each treatment room after every patient. This is an important reason why we demand timeliness of you and ourselves. We use a system of automated messages to confirm dental appointments. We **require** that you reply to these messages and confirm your appointment within 24 hours of the appointment to remain on the schedule. **If we do not hear from you within 24 hours of the appointment your appointment will be forfeited.**

4. If you miss an appointment, it is critical to your health to make it up, to avoid setbacks in the care and maintenance of your teeth and gums. Failure to make an appointment not only compromises your health but it also inconveniences other patients who may have requested an office visit during your reserved appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to give us notice 48 business hours before the appointment, to reschedule. There is a $75 fee for all no-show and cancelled appointments without 48 business hours' notice. This fee is not covered by insurance.

5. We strive to run an office that focuses on Dentistry not Banking or Accounting. In order to achieve this, we require 50% of your total patient out of pocket investment in order to reserve any future scheduled treatment appointment. We have several financial options available for all our patients. Please speak with any of our team members if you have any questions regarding financial options.

6. Emergencies: It is our goal to eliminate all the potential dental emergencies that you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we want you to be assured that we will take care of you. We define a true emergency as ***swelling, bleeding, severe pain that has kept you up at night or requires medication or a restoration in a visible area that falls out***. If you experience any of these conditions, we ask that you call us right away. We will provide you with the next available emergency appointment. We set aside time daily for emergencies.

Yours in Dental Health,
Dr. Diaz and Team
I have read and agree to the terms of the Appreciated Patient Letter.

X_____ _____ _____
(Patient Signature) (Patient's Printed Name) (Date)

HIPAA
CONSENT FOR RELEASE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. These rights have been outlined in the Notice of Privacy Practices (NOPP).

I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release the practice, its employees and agents for any and all disclosures as stated in the NOPP.

I understand that I may request in writing that you restrict how my private and super-confidential information is used or disclosed to carry out treatment and for payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I hereby authorize Stephanie Diaz, D.M.D. and her employees to use and disclose any necessary information from my dental record, verbally or by mail, email or fax in accordance with the Notice of Privacy Practices.

Print Name: _____ Date: _____

Signature: X_____

ANY PERSONS YOU GIVE PERMISSION TO SPEAK TO ON YOUR BEHALF:

FULL NAME: _____PHONE NUMBER_____

INSURANCE DISCLAIMER

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted.

Any treatment plan that our office proposes to you is an estimate of what your insurance coverage will be, it is not a guarantee. If you need exact payment of benefits, then a pretreatment is required. If you would like this done, you must specify to the front office team before any work is initiated. (This takes 6-8 weeks). ____ (Initial)

Please note we do not accept nor participate with any DMO/HMO insurance plans, Medicaid or discount plans. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your insurance plan does not pay within 120 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund check. Also remember dental insurance plans are not designed to cover all of your dental needs.

I, _____, have chosen to allow Diaz Smile DMD to file my insurance and accept full responsibility for this account and for all dentistry performed upon my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits. I also understand that if my insurance company does not pay within 120 days of my date of service then I will become responsible to pay at that time.

Print Name: _____ Date: _____

Signature: X_____