Welcome to Elizabeth Patino DMD, PA's dental practice.
Please complete the following confidential form in ink.
Thank you for choosing us as your dental healthcare provider.

Patient Information

Name: ____
SS#: _____________________ Date of Birth: __/__/_______
Address: ____
City: _____________________ State: _____ Zip: _________
Status: ☐Minor ☐Divorced ☐Single ☐Widowed ☐Married ☐Separated

Home Phone: (___) __________________
Work Phone: (___) __________________
Cell Phone: (___) __________________
Preferred Contact: ☐Home ☐Work ☐Cell

In case of Emergency

Contact Name: _____________________________________
Emergency Phone: (___) ________________

Person Responsible for this Account

Name: ____
Relationship to Patient: ____
Address: ______________________________________
Name of Employer: ____
City: ________________ State: ____ Zip: ________
Home Phone: (___) ____________ Date Employed: __/__/____
Date of Birth: __/__/_____ SS#:_______________
Work Phone: (___) ____________ E-mail: ________________________

Insurance Information: ☐*No Insurance*

Name of Insured: ______________________________
Insurance Carrier: ____
Relationship to Patient: _______________________
Member ID: ________________Group/Policy #: _________________
Date of Birth __/__/_____ SS# _________________
Address of Insurance: ____
Billing Address ______________________________
City: __________________________________ State: ____ Zip:________
City:_________________ State: ____ Zip: ________

Dental History

Name of previous dentist	Are your teeth sensitive to sweet/sour? ☐No ☐Yes
Date of last dental visit __/__/____	Do you feel pain to any of your teeth? ☐No ☐Yes
Main dental concern?	Do you have any sores/lumps in your mouth? ☐No ☐Yes
Self perception of dental health? ☐Poor ☐Stable ☐Excellent	Have you had any head, neck or jaw injuries? ☐No ☐Yes
Reason for lack of care? ☐Fear ☐Anxiety ☐Money ☐None	Have you ever experienced (TMJ) problems? ☐No ☐Yes
Past dental experience? ☐Good ☐Bad	Do you have frequent headaches? ☐ No ☐Yes
Type of care in the past? ☐Preventive ☐Extensive ☐None	Do you clench or grind your teeth? ☐ No ☐Yes
Sugar intake? ☐Low ☐Med ☐High	Have you had any orthodontic treatment? ☐No ☐Yes
Soda intake? ☐Low ☐Med ☐High	Do you wear dentures or partials? ☐No ☐Yes
Processed food intake? ☐Low ☐Med ☐High	Do you bite your lips or cheeks frequently? ☐No ☐Yes
Chewing gum? ☐None ☐Sugar ☐Sugar-free	Have you ever had any difficult extractions? ☐No ☐Yes
Dry mouth? ☐No ☐Yes	Alcohol Intake? ☐Min ☐Moderated ☐High ☐None
Do your gums bleed while brushing? ☐No ☐Yes	History of Smoking? ☐No ☐Yes
Do your gums bleed while flossing? ☐No ☐Yes	History of Smokeless Tobacco? ☐No ☐Yes
Type of toothbrush? ☐Manual ☐Battery ☐Electric	Bulemia/Anorexia? ☐No ☐Yes
How often are you brushing?☐None ☐Daily ☐After every meal	Controlled Substance Abuse? ☐No ☐Yes
Type of floss? ☐String ☐Floss Picks	Other habits?☐Nail Biting ☐Thumb sucking ☐Mouth breathing
How often do you floss? ☐None ☐Daily ☐After every meal	Is there anything you would change about your smile?
Other Products? ☐Mouthwash ☐Water pick ☐Toothpicks	
Are your teeth sensitive to hot/cold? ☐No ☐Yes	

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Medical History

Primary Physician ____________________ Office Phone Number (___)_________ Date of Last Exam __/__/____

Are you under any medical treatment now?	☐ No	☐ Yes: ______________________________
Have you ever had a serious illness or operation?	☐ No	☐ Yes: ______________________________
Have you been hospitalized within the last 5 yrs?	☐ No	☐ Yes: ______________________________
Are you taking non-prescription medication(s)?	☐ No	☐ Yes: ______________________________
Are you taking any medication(s)?	☐ No	☐ Yes: ______________________________
Are you exposed to blood (occupation)?	☐ No	☐ Yes
Have you ever taken Fen-Phen/Redux?	☐ No	☐ Yes
Do you have a persistent cough?	☐ No	☐ Yes
Are you wearing contact lenses?	☐ No	☐ Yes

Women only:

Are you pregnant or think you might be?	☐ No	☐ Yes
Are you taking oral contraceptives?	☐ No	☐ Yes
Are you nursing?	☐ No	☐ Yes

Are you allergic to the following?

Local Anesthetics	☐ No	☐ Yes
Antibiotics	☐ No	☐ Yes
Sulfa Drugs	☐ No	☐ Yes
Barbiturates	☐ No	☐ Yes
Sedatives	☐ No	☐ Yes
Iodine	☐ No	☐ Yes
Aspirin	☐ No	☐ Yes
Metals	☐ No	☐ Yes
Latex Rubber	☐ No	☐ Yes

Others: ____________________________

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

	No	Yes		No	Yes		No	Yes
High Blood Pressure	☐	☐	Respiratory Problems	☐	☐	Cancer	☐	☐
Heart Disease	☐	☐	Tuberculosis	☐	☐	Radiation Therapy	☐	☐
Heart Attack	☐	☐	Emphysema	☐	☐	Anemia	☐	☐
Stroke	☐	☐	Asthma	☐	☐	Low Blood Pressure	☐	☐
Angina/Chest Pain	☐	☐	Fainting/ Seizures	☐	☐	Recent Weight Loss	☐	☐
Heart Murmur	☐	☐	Frequently Tired	☐	☐	Kidney Disease	☐	☐
Valve Prolapse	☐	☐	Thyroid Problems	☐	☐	Liver Disease	☐	☐
Cardiac Pacemaker	☐	☐	Rheumatic Fever	☐	☐	Hay Fever/ Allergies	☐	☐
Swollen Ankles	☐	☐	Joint Replacement	☐	☐	Stomach Problems	☐	☐
Easily Winded	☐	☐	Arthritis	☐	☐	Hepatitis/ Jaundice	☐	☐
Diabetes	☐	☐	Glaucoma	☐	☐	AIDS/ HIV	☐	☐

Have you had any health problems that are not listed? ☐ No ☐ Yes: ______________________________

Notes: ____

Authorization and Release

I certify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____ __/__/_____

Signature of Patient (or Parent/Guardian if minor) Date

____ __/__/_____

Signature of Dentist Date

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Disclosures to Friends and/or Family Members (HIPPA)

I, (Print your name) ___________________________ give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below: (Please list any family members as well as any others in the space below)

Family members:
____

Consent for Photographing or Other Recording for Security and /or Health Care Operations

*___________ **(Patient Initials)** I consent to photographs, videotapes or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvements activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the practice without a specific written authorization from me or my legal representative in less otherwise required by law.

Consent to Receive Text Messages or Emails about Appointments Reminders:

Patients in our practice may be contacted via email or text messaging to remind you of an appointment.

*__________ **(Patient Initials)** I Consent to received text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive appointments reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.

The **cell** phone number that I authorized to received text messages for appointment reminders is (_____)__________________.

The **email** that I authorized to receive text messages for appointments reminders is ______________________________.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carries for pricing plan and details).

Signature: ____ Date: __/__/_____

Patient Name (print):____________________________________ Date: __/__/_____

Revocation (if you do NOT want us to email or text you).

I hereby revoke me request for future communications via email and/or text.

____ I hereby revoke my request to receive any future appointments reminders via text messages.

____ I hereby revoke my request to receive any future appointment reminders via email.

NOTE: This revocation only applies to communication from this practice.

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CONSENT for Use and Disclosure of Protected Health Information
&
Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). The purpose of this consent is for Elizabeth Patino, DMD, pa's to use and disclose my PHI to carry out treatment, payment activities, and healthcare operations.

I have the right to read the Notice of Privacy Practices before deciding whether to sign this consent. The notice provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures that can be made of my PHI, and of other important matters about my PHI. The notice is posted in the reception counter, and I have being encouraged to read it carefully and completely before signing this consent.

I understand that Dr. Patino reserves the right to change her privacy practices as described in the Notice of Privacy Practices. If changed, a revision with the changes will be displayed. Those changes may apply to any of my maintained PHI.

I may obtain a copy of this form and/or the Notice of Privacy Practices, including any revisions.

I understand my right to revoke this consent at any time by submitting written notice to Dr. Patino.

I understand that revocation of my consent will not affect any action taken in reliance on my consent before this written notice of revocation has being received. I also understand that Dr. Patino may decline to treat me or to continue treating me after I have revoked my consent.

I have had full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices and am bound to abide by such restrictions.

I understand that by signing this form I am giving consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

_____________________________ ___/___/____ ____________________ ___________________
Signature of Patient Date Printed Name SS#
(or Parent/Guardian if minor)

OR ***REVOCATION*** **of Consent for Use and Disclosure of Protected Health Information &**
Notice of Privacy Practices Acknowledgement

I *revoke* my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare options. I understand that revocation of my consent will not affect any action taken in reliance on my consent before this written notice of revocation has being received. I also understand that Dr. Patino may decline to treat me or to continue to treat me after I have revoked my consent.

_____________________________ ___/___/____ ____________________ ___________________
Signature of Patient Date Printed Name SS#
(or Parent/Guardian if minor)

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Financial Policy

Please review Elizabeth Patino, dmd, pa's financial policy. It is important for you to understand it prior to treatment. We welcome any questions you may have.

1. Full payment for treatment provided is due at the time of service. All major credit cards, checks and cash are accepted.

2. Please provide *24-hr notice* prior to changing *any* appointments. There is a *$70 fee* for failing to keep an appointment or for cancellations without proper notice. We reserve this time exclusively for you.

3. We will gladly copy your dental records for $35.

Dental Insurance

1. An insurance policy is a contract between you and your insurance company. We are *not* a party to that contract.

2. Your account balance is your responsibility whether your insurance pays or not.

3. In order to accept assignment of benefits, you must be pre-approved on our extended payment plan *or* provide a credit card number with authorization to bill your account for any balance.

4. For your convenience, we will gladly bill your insurance company. Please bring all of your insurance information and any original claim forms prior to treatment.

5. If your insurance fails to pay your account in full within 45 days, the balance will be automatically transferred to your credit card.

6. Please be aware that some procedures may be "non-covered" services and not considered reasonable and necessary under your insurance policy. You are required to pay the full amount charged regardless of your insurance's determination of usual and customary rates or amounts of assignment for these types of services.

Authorization and Release

I certify that I read, understand, and agree to the above information and have had the opportunity to ask questions. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payors. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____________________________ ___/___/____ ___________________ __________________
Signature of Patient Date Printed Name SS#
(or Parent/Guardian if minor)