WELCOME TO OUR PRACTICE

We will like to know your dental concerns and expectations so we can provide you with the best dental care.

* ***Why did you leave your last dentist?***

* ***What may we do to make your visit more pleasant?***

* ***What are your dental concerns?***

* ***What would have to change in your dental appearance for you to be pleased with your smile?***

* ***What do you value the most in a dental practice?***

* ***Do you have any concerns or questions?***

Name: _____ Date: _____

Parent / Guardian: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone numbers: Cell _____ Home _____ Work _____

e-mail address: _____ Birth date: _____ Age: _____ Sex: M F

SS#: _____ License#: _____ ◯ Single ◯ Married ◯ Other

How did you hear about our practice? _____

Person to contact for emergency: _____

Relationship: _____ Cell: _____

Consent for treatment:

1. I hereby authorize the doctor or designated staff to make x-rays, study models, photographs and any other aids deemed appropriate by the doctor to make a thorough diagnosis of (name of the patient) _____ _____s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read and understood all of the above.

_____ _____

Patient / Guardian Signature Date

Insurance Information

Insurance carrier: _____ Insurance phone: _____

Policy holder: _____ Employed at: _____

ID#: _____ Group#: _____

Date of birth: _____ SS#: _____

Patient's Name: _____

DENTAL HISTORY

Please indicate the following:

Last:

Dental Visit: _____ Cleaning: _____

FM X-Rays: _____

What was done at your last dental visit?

_____

Previous Dentist's Name:

_____

Frequencies:

Dental Exams: _____ Brush your teeth: _____

Floss: _____ Other dental aids: _____

	Y	N
Are your teeth sensitive to:		
Hot or cold?	◯	◯
Sweets?	◯	◯
Biting or chewing?	◯	◯
Have you noticed any mouth odors?	◯	◯
Have you noticed a foul taste in your mouth?	◯	◯
Do you frequently get cold sores, or blisters or other oral lesions?	◯	◯
Do your gums bleed or hurt?	◯	◯
Have your parents experienced gum disease or tooth loss?	◯	◯
Have you noticed any loose teeth or a change in your bite?	◯	◯
Does food get caught in your teeth?	◯	◯
If yes, where? _____		
Do you:		
Clench or grind your teeth?	◯	◯
Bite your lips or cheeks regularly?	◯	◯
Hold foreign objects in your mouth?	◯	◯
Mouth breathe while awake/asleep?	◯	◯
Have tired jaws especially in the morning?	◯	◯
Smoke or chew tobacco?	◯	◯
Have you ever had:		
Orthodontic treatment?	◯	◯
Oral Surgery?	◯	◯
Periodontal treatment?	◯	◯
Your teeth or bite adjusted?	◯	◯
A bite plate or mouth guard?	◯	◯
A serious injury to mouth/head?	◯	◯
If yes, describe_____		
Have you ever experienced?		
Clicking/Popping of the jaw?	◯	◯
Pain? (Jaw joint, ear, side of face)	◯	◯
Trouble opening/closing mouth?	◯	◯
Trouble chewing on either side of the mouth?	◯	◯
Headaches, neck aches, or shoulder aches?	◯	◯
Sore muscles (neck, shoulders)?	◯	◯

MEDICAL HISTORY

Please indicate the following:

Have you been under the care of a doctor during the past two years? _____

If yes, for what? _____

Physician's name: _____ Phone: _____

Have you taken any medication or drugs during the past two years? _____

Are you taking any medication, drugs or pills now? _____

If yes, please list name(s): _____

Are you aware of having an allergic reaction to any medication or substance? _____

If yes, please list: _____

Have you been diagnosed with osteoporosis? _____

Indicate which of the following you have had or have now.

	Y	N
Heart (surgery, disease, attack)	◯	◯
Chest pain	◯	◯
Congenital heart disease	◯	◯
Heart Murmur	◯	◯
High blood pressure	◯	◯
Mitral valve prolapse	◯	◯
Artificial heart valve	◯	◯
Heart pacemaker	◯	◯
Rheumatic fever	◯	◯
Arthritis/Rheumatism	◯	◯
Cortisone medicine	◯	◯
Swollen ankles	◯	◯
Stroke	◯	◯
Diet (Special/Restricted)	◯	◯
Artificial joints	◯	◯
Kidney trouble	◯	◯
Ulcers	◯	◯
Diabetes	◯	◯
Thyroid problems	◯	◯
Glaucoma	◯	◯
Contact lenses	◯	◯
Emphysema	◯	◯
Tuberculosis	◯	◯
Asthma	◯	◯
Hay fever	◯	◯
Latex sensitivity	◯	◯
Allergy or hives	◯	◯
Sinus trouble	◯	◯
Radiation therapy	◯	◯
Tumors	◯	◯
Cold sores/ fever blisters	◯	◯
Hepatitis A (Infectious) B (Serum)	◯	◯
Venereal Disease	◯	◯
AIDS	◯	◯
HIV Positive	◯	◯

	Y	N
Blood transfusion	◯	◯
Hemophilia	◯	◯
Sickle cell disease	◯	◯
Bruise easily	◯	◯
Liver disease	◯	◯
Yellow Jaundice	◯	◯
Neurological disorder	◯	◯
Epilepsy or seizures	◯	◯
Fainting/dizzy spells	◯	◯
Nervous/Anxious	◯	◯
Psychiatric care	◯	◯
Psychological care	◯	◯

Answer the following:

Do you use more than two pillows to sleep?	◯	◯
Have you lost or gained more than 10 pounds in the last year?	◯	◯
Have you ever had a sleep study?	◯	◯
Have you ever been told you should wear a CPAP?	◯	◯
Are you excessively tired during the day?	◯	◯
Have you been told that you gasp for air or stop breathing while sleeping	◯	◯
Do you snore?	◯	◯

Do you have any disease, condition, or problem not listed?

_____

Women:

Are you pregnant?	◯	◯
If yes, how many months? _____		
Nursing	◯	◯
Are you taking birth control pills?	◯	◯

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER.
I HAVE ANSWERED TO ALL OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTH CARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OF ANY CHANGE IN MY HEALTH OR MEDICATION.

Patient / Guardian signature: _____ Date: _____

Consent for use and Disclosure of Health Information

Section A: patient giving consent

Name: _____

Address: _____ Apt: _____

Phone: _____ E-mail: _____

Patient#: _____ SS#: _____

Section B: to the patient - - please read the following statements carefully

Purpose of Consent: by signing this form, you will consent our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: you have the right to read our notice of privacy practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting: Martha Restrepo at (305) 666-3824.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative´s Name: _____

Relationship to Patient: _____

You are entitled to a copy of this consent after you sign it.

Acknowledgement of Receipts of Notice of Privacy Practices

You may refuse to sign this Acknowledgement

I, _____ , have received a copy of this office´s Notice of Privacy Practices.

Print name	Signature	Date

For office use only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

Video, Audio, and Photographic Release

The undersigned hereby authorizes Doctors to use, reproduce and publish video, audio, photography or computer illustrations of your teeth/mouth, for educational and media purposes and you waive claim against any party based on the usage of images or make any claim that the use of the images defames you or constitutes infringement of your rights to privacy or any other right you may enjoy. It is not mandatory that you sign this paragraph and you agree that if you choose to do so, it is done so freely and voluntary.

Patient / Guardian Signature

Doctor Signature

Witness Signature

Date

Release of Dental Benefits:

It is our pleasure to accept patients who have dental insurance. Our office will be happy to file your insurance forms at no charge as a courtesy. However, we do require your copayment deductible (usually 20%-50%) to be paid at the time of service. We cannot bill your insurance company unless you give us your insurance information. You hereby authorize insurance claim reimbursement of dental benefits be paid directly to T.M.J. Dental consultants, Inc. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract, if your insurance company has not paid your account in full within 60 days, the balance will be automatically due and payable by you.

Patient / Guardian Signature

Date

Financial Policy:

We treat every patient with equal care with or without insurance. Unfortunately, some insurance companies do not always cover certain established, routine and accepted procedures. We feel you deserve the best treatment possible and should not be influenced by the insurance company´s policy. Since we do not have access to each plan´s contract, it is difficult for us to know every limitation, deductible, or allowance for every procedure. It is important for you to know your policy´s coverage. Our practice is committed to providing the best treatment for our patients and we charge what is customary and reasonable for our area. You are responsible for payment regardless of any insurance company´s arbitrary determination for usual and customary rates.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all amounts that are at least 30 days past due at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection.

I have read the financial policy. I understand and agree to this financial policy.

Patient / Guardian Signature

Date