# Los Rios Dental

**Cosmetic and Family Dentistry**

## Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Birth Date: _____ Gender: _____ Family Status: _____

Social Security #: _____ Email: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

**Have you ever had any of the following? Please check those that apply:**

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Sulfa Drugs
- ☐ Aspirin or Iodine
- ☐ Barbiturates
- ☐ Other:_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

## Medical History Update (Office Use Only)

_____ _____ _____
Dr. Date Dr. Date Dr. Date

## Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Insurance Website ☐ Web Search ☐ Plano Profile ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

## Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Cell: _____

Address: _____

Street Apartment #

_____

City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City, State Zip Code Phone

## Insurance Information

**Primary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

# Los Rios Dental
## Cosmetic & Family Dentistry

## Consent to Disclose
### Private Healthcare Information
### For treatment, Payment and/or Healthcare Operations

I,_____, hereby authorize and consent Los Rios Dental, P.A. To release any and all medical dental and /or psychological reports or records , including but not limited to, medical /dental notes physician narratives, office notes ,operative notes, discharge summaries, Doctor's/Dentist's orders, Nurse's notes lab reports, test results physical therapy progress notes, patient progress reports, diagnosis, post-operative reports, post-diagnosis, pathology reports, x-rays, MRI's any records reflecting treatment for substance abuse, mental illness, AIDS, HIV virus alcohol abuse, including any x-rays, diagnostic studies, laboratory slides, clinical abstract, histories, charts, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental condition, treatment, care or hospitalization, and any other personal health information regarding my medical/dental care as necessary to carry out treatment, obtain payment, and/or conduct other healthcare operations.

The release of the matters listed above is being authorized for purposes of obtaining medical/dental treatment, payment for such services and other healthcare operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further understand that I have the right to review Los Rios Dental, P.A.'s privacy notice and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire.

Signed this _____Day of _____, 20_____.

_____
**Signature**

_____
**Print Name**

_____
**Patient's Name**

Special Restrictions:

_____

_____

LOS RÍOS DENTAL
Cosmetic & Family Dentistry

## Financial Agreement

**Payment Policy**: Payment is expected in full for each appointment as services are rendered. Payment options are cash, check, credit card (VISA, Master Card, Discover) and Care Credit. _____

**Dental Insurance**: As a courtesy service to our patients, our practice accepts most dental PPO dental insurance plans as a PPO in-network provider. However, we remind you that your specific policy is an agreement between you and your insurance company. **Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.** All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment. _____

**Cash Discounts :** As a courtesy to our patients with **no dental insurance**, we offer a **10% discount** for any dental treatment rendered. (excluding exams & x-rays). _____

**Past Due Accounts** : If your account is past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. _____

**Returned Checks** : There is a fee of $50.00 for any checks returned by the bank. _____

**Cancellation Policy** : Our office requests **48 hours** notification if you are unable to keep your scheduled appointment. **If** less than **24 hours** notice, a $50 fee will be charged to your account. Appointments reserve a specific time with the dentist or hygienist to perform and provide the care you need. These schedule times are planned for your convenience and hold great value. In addition, if you are **more than 15 minutes** late, we will have to reschedule the appointment. We ask that all of our patients to be on time and trust that you will keep your appointment. Patients with three missed appointments may be asked to transfer their records to another doctor. _____

**Effective Date** : Once you have signed this agreement, you agree to **ALL** of the terms and conditions disclosed and agreement will be in full force and effect. _____

This is an agreement between us (Los Rios Dental) and the patient named on this form. By executing this agreement, you are agreeing to pay for all services that are received.

Name:_____

Signature:_____ Date:_____