WELCOME!

1. PATIENT INFORMATION

Date:

Last Name ______ First Name ______ MI ______

Sex ☐ Male ☐ Female Soc. Sec. # ______ Date of Birth ______ Age ______

Mailing Address ______ City ______ State ______ Zip Code ______

Email ______ Cell Phone (____)______ Home Phone (____)______

Employer ______ Work Phone (____)______ Occupation ______

Emergency Contact ______ Relationship ______ Phone # (____)______

If under 18, Name of Parent ______ Parent Soc. Sec. # ______

Parent Employer ______ Parent Phone (____)______

Reason for today's visit? ______

How did you hear about us? ☐ In-home Mailer ☐ Social Media ☐ Insurance ☐ Practice Website ☐ Google ☐ Other______

☐ Family/Friend/Coworker: Who can we thank for your visit? ______

2. DENTAL INSURANCE INFORMATION *(Primary Carrier)*

Insured's Name ______

Insured's Employer ______

Insured's DOB ______

Insurance Co ______

Insurance Co Address ______

Insurance Phone # ______

Group # ______ Local # ______

3. DENTAL INSURANCE INFORMATION *(Secondary Carrier)*

Insured's Name ______

Insured's Employer ______

Insured's DOB ______

Insurance Co ______

Insurance Co Address ______

Insurance Phone # ______

Group # ______ Local # ______

4. FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards, or one of the third-party financing options we provide.

☐ **Please check if you would like more information about financing options.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, credit card or one of the third-party financing options we provide.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

For a detailed description of our privacy practices, please see our "Notice of Privacy Practices" folder at the front desk.

Consent:
I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

______
Patient Signature/Legal Guardian

______
Date

5. AUTHORIZATION TO RELEASE INFORMATION

I, ______, authorize the following person to have access to information covered under the Privacy Practice regarding myself.
Your Name

______
Name (Printed)

______
Relationship

6. DENTAL HISTORY Please mark (x) on any of the following conditions that apply to you

Patient Name (print):

Appearance
- ☐ Discolored teeth
- ☐ Flat/worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Crowding
- ☐ Spaces/missing teeth
- ☐ Deep bite

Pain/Discomfort
- ☐ Sensitivity (hot, cold, sweets)
- ☐ Pressure/pain with chewing
- ☐ Broken teeth/fillings
- ☐ Dry mouth
- ☐ Other: ______________

Function
- ☐ Grinding/clenching
- ☐ Morning headaches
- ☐ Jaw joint (TMJ) pain
- ☐ Jaw joint (TMJ) clicking/popping
- ☐ Speech impediment
- ☐ Mouth breathing
- ☐ Sore muscles (head, neck)
- ☐ Difficulty opening or closing
- ☐ Difficulty chewing on either side

Periodontal (Gum) Health
- ☐ Bleeding, swollen, irritated gums
- ☐ Bad breath
- ☐ Loose, tipped or shifting teeth
- ☐ Previous perio/gum disease

Habits
- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/lip biting
- ☐ Chewing on ice/foreign objects

Sleep Pattern or Conditions
- ☐ Sleep apnea
- ☐ Snoring

Social

Tobacco packs per day ______________

Alcohol frequency ______________

Drugs frequency ______________

Previous Comfort Options
- ☐ Nitrous oxide
- ☐ Oral sedation (pill)
- ☐ IV sedation

Frequent/Daily Use:
- ☐ Soda/sweet tea
- ☐ Coffee with creamer/sugar
- ☐ Sports/energy drinks
- ☐ Candy/sweets
- ☐ High carb diet

Please share the following dates: Your last dental visit ______________ Your last cleaning ______________

What is the most important thing to you about your dental visit today? ______________

____

On a scale of 1-10, with 10 being the highest rating: Dental Anxiety Happy with your smile

What would you like to change about your smile? ☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth ☐ Teeth Sensitive to hot, cold, sweets or pressure ☐ Other

7. MEDICAL HISTORY Please mark (x) as your response to indicate if you have or have had any of the following

Medical Allergies
- ☐ Antibiotics (Penicillin/Amoxicillin /Clindamycin)
- ☐ Opioids (Percocet, Oxycodone, Tylenol 3)
- ☐ Latex
- ☐ Local anesthetics
- ☐ NSAIDs

Other allergies/comments

____

____

____

Cancer

Type ______________
- ☐ Chemotherapy
- ☐ Radiation therapy

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Heart conditions
- ☐ Heart surgery
- ☐ High/low blood pressure
- ☐ Pacemaker
- ☐ Stroke

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease

Gastrointestinal
- ☐ Reflux
- ☐ Gastrointestinal disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood disorders
- ☐ Bruise easily
- ☐ Excessive bleeding

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness/fainting
- ☐ Drug/alcohol addiction
- ☐ Seizures
- ☐ Psychiatric illness

Respiratory
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Respiratory problems
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Tuberculosis

Viral Infections
- ☐ AIDS
- ☐ HIV positive
- ☐ HPV
- ☐ Cold sores

Women
- ☐ Currently pregnant Due date: _______
- ☐ Nursing

Are you under the care of a physician? If yes, please explain ______________

Physician Full Name ______________ Phone (______)______________

Have you had a serious illness, operation, or hospitalization in the past 5 years? If yes please explain ______________

____

Please check if you have any of these conditions: Artificial Heart Valve Previous Infective Endocarditis Damaged Heart Valves in Heart Transplant Unrepaired Cyanotic CHD Repaired CHD with Residual Defects

Please list medications currently taking: ______________

____

Have you ever in the past, or are you now currently taking, any medications for Osteopenia/Osteoporosis or Bone Disease? If yes, please list medications:

____

Are you on blood thinners? If yes, please list: ______________

Consent:

I hereby authorize Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

______________ ______________ ______________

Signature of Patient/Legal Guardian *Print Name* *Date*

____

Dentist/Hygienist Signature

Office Policies:

Welcome to our office. We are committed to serving you with the best possible dental care and services. The following information is provided to help avoid any misunderstandings between you and our office.

Please treat our staff with respect.

We ask that you do not eat or smoke in the office.

Please restrict your cell phone use to necessary calls only. They are an interruption to patient care.

It is required that you update your medical history and medication list periodically. Please comply.

Our office participates in a variety of insurance plans. It is your responsibility to:

- Bring your insurance card or information each visit.
- Be prepared to pay for your co-pay, deductible, or co-insurance at the time services are rendered.
- Payment in full is expected at the time services are rendered. Payment may be made by cash, Visa, MasterCard or Discover.

We will gladly submit your claims with your insurance company. Failure of your insurance company to pay does not release you of your obligation to pay for all services and materials provided by this office.

In an attempt to better serve our patients, a minimum of 24 hour notice is requested for cancellation of appointments. The doctor and staff schedule time for your care. Adequate cancellation notice allows us to make that appointment time available to others. Broken appointments without 24 hours cancellation notice will result in a $50.00 fee per missed visit.

Patients under the age of 18 must have a parent or guardian present while he/she is in the office. If the minor is not accompanied by a parent/guardian written authorization from the parent/guardian to treat the minor is required along with payment in advance of services rendered for that visit.

Our practice firmly believes that a good doctor/patient relationship is based on good communication. Questions about these policies are welcomed and should be directed to our front office. Thank you for your cooperation and understanding.

Vivian Medina, D.D.S

My Personal Smile Evaluation

When I see a picture of myself...

_____ I wish my teeth were whiter.

_____ I wish I had a wider, broader smile.

_____ My teeth have rough edges.

_____ My gums show too much [ ]or not enough [ ] when I smile.

_____ My top teeth don't show enough.

_____ I have discolored areas between my teeth.

_____ There is too much space between some of my teeth.

_____ I am not totally pleased with my smile.

_____I am interested in options available for enhancing my smile.

_____ I am completely satisfied with my smile.

_____I would like to be provided with more information regarding surgical and cosmetic procedures.

My teeth are: _____ crowded _____ uneven

_____ crooked _____ overlapped

Appointment Cancellation Policy

We pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you. We reserve the right to charge patients who do not reschedule with adequate notice, or who fail to keep their scheduled appointments.

How to Cancel Your Appointment

In order to be respectful of the needs all of Vivian Medina DDS patients, if it is necessary to cancel your reserved appointment we require that you contact our office by 10:00am one (1) working day in advance. Appointments are in high demand and your early cancellation will give another person the possibility to access timely dental care. To cancel an appointment, please call (813)264-0286 to speak with an office representative. If you do not reach an office representative, you may leave a detailed message on the office voicemail. You may not cancel a scheduled appointment via email.

No Show Policy

A "no show" appointment occurs when a patient misses an appointment without cancelling by 10:00am one (1) working day in advance. No shows inconvenience patients who need access to dental care in a timely manner. Last minute/late cancellations are considered "no show" appointment. Failure to be present at the time of a reserved appointment will be recorded in your patient chart as a "no show". The first "no show" will result in a $25-fee being applied to your account, as well as a letter being sent to your home alerting you than an appointment was missed without canceling. If there is a second "no show" a $50-fee will be billed to your account and a second letter will be sent. A third "no show" will result in suspension of services and dismissal from our dental practice. Exceptions to this policy must be approved by the Office Manager.

By signing below, I certify that I have read and understand the terms and conditions of Vivian Medina DDS' appointment cancellation policy.

X____ Date ____________________

Oral Cancer Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Studies also suggest that human papillomavirus (HPV) plays a role in more than 20% of oral cancer causes.

* Oral cancer risk by patient profile as follows:

Increased risk:	patients ages 18-39 & sexually active patients (HPV)
High risk:	patients age 40 and older; tobacco users (ages 18-39, any type within 10 years)
Highest risk:	patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

In our practice, as your healthcare provider, we seek to provide you access to the newest and most effective scientific screening and treatment. In 2009 the StarDental® Identafi® system was introduced. This multispectral medical device greatly enhances our ability to find early signs of cancer and dysplasia in the mouth. Historically our practice has used white light in examination for oral cancer. The use of narrow band violet light and green-amber reflected light helps us detect in the oral tissue various problems including cancer lesions and dysplasia.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is $71.

Yes. I authorize the clinician to perform the oral cancer screening. I accept financial responsibility for this enhanced examination if my insurance company does not currently cover this procedure.

Print Name: ______________________________

Signature: ______________________________ Date: ____________________

No. I would prefer not to have an oral cancer screening at this time.

Print Name: ______________________________

Signature: ______________________________ Date: ____________________