Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
Last First MI Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Hm #: (____) _____ Cell / Other #: _____

Wk #: (____) _____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Person Responsible for Account: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Contact #: (____) _____ Ext: ____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Relative or Friend not living with you (for emergency).

His / Her Name: _____ Relation: _____

Contact #: (____) _____

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Continued on Back

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

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

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

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

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

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Herpes / Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol / Drug Abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints / Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer / Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Treatment
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease / Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack / Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

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

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Signature Date

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

_____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

_____ Patient Signature Date

_____ Dentist Signature Date

Has there been any change in your health status since your last visit? Y N

If Yes, please explain. _____

_____ Patient Signature Date

_____ Dentist Signature Date

DESIGNING SMILES BY DR. DIAZ

Office Financial Policy

- We try to make your dental care as cost-efficient as possible. One measure we have taken to keep cost down is to minimize our billing and accounting; therefore, we ask for payment at the time of service. Financial arrangements must be established before our office can continue with any recommended treatment.

- All patients who are seen in our office for a Comprehensive Exam are provided with a Treatment Plan. Our office accepts Visa, Master Card, Discover and cash as forms of payments for your treatment plan. A monthly payment arrangement, if approved for your treatment, may be made through **CareCredit.**

- Should your account become delinquent (past due), we will continue to send a statement until the balance is 90 days old. If your account remains delinquent, two consecutive letters will be sent in order to avoid the necessity of pursing further collection actions. Should your account remain delinquent, we will forward the balance to our collection agency.

- **In cases of divorce or separation, the parent bringing the child is responsible for payment.**

- **Cancellation Policy**: If it becomes necessary to reschedule your appointment, we request the courtesy of 24 hours notice. If you cancel, do not show or miss your appointment without the required notice we will assess a $35.00 non-refundable missed appointment service charge. This fee is strictly enforced.

  In order to avoid a cancelation charge, please state the best way to be notified of appointment: Text#: _____,
  Email address: _____,and/or
  Facebook (please state FB Name)_____.

- If you have any questions regarding your account balance or if you are experiencing circumstances beyond your control, please contact our office. We will be happy to assist you with your questions or to set up special payment arrangements.

Our practice firmly believes that a good doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication. We have instructed our staff to make every effort to clarify any misunderstandings you may have concerning your account balance or our financial policies. We hope to avoid any possible disagreements over payment for professional services.

Our patients and our relationships with our patients are very important to us. If you have any questions or need assistance, please contact us immediately.

X_____
Patient and/or Legal Guardian Signature Date

Consent to Perform Dentistry

1. I hereby authorize and direct the dentist(s) of: **Designing Smiles By Dr. Diaz** and/or dental auxiliaries of his/her choice, to perform the following dental treatment, or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

A. Preventative hygiene treatment, (prophylaxis) and the application of topical fluoride.
B. Application of plastic "sealants" to the grooves of the teeth.
C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
D. Replacement of missing teeth with dental prosthesis (bridges, partial dentures, full dentures).
E. Removal (extraction) of one or more teeth.
F. Treatment of diseased or injured oral tissues (hard and/or soft).
G. Use of sedative drugs to control apprehension and/or disruptive behavior.
H. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
I. Use of general anesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patient follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being, in the professional judgment of the dentist(s).
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face, and tongue, allergic reactions, hematoma (swelling or bleeding at or near of the injection site), fainting, lip or cheek biting resulting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medication in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
7. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.
8. I hereby state that I have read and understand this consent and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time I choose to terminate it.

Date: _____ File No:_____

Patient's Name: _____

Name of Parent or Guardian: _____

Relationship to Patient: _____

X_____

Signature: Patient or Parent or Guardian Witness

CONSENT FOR USE AND DISCLOSURE OF DENTAL HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ SS #:_____

Address: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to 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 is posted in our office. Should you have any concerns, we encourage you to read it carefully and completely before signing.

We reserve the right to change our privacy practices 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 we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Designing Smiles By Dr Diaz (Cecilia C. Diaz, D.D.S.)
3714 Euclid Avenue Tampa, FL 33629 Phone: (813)835-8900 Fax: (813)835-8614

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 this 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, _____ **(PRINT NAME)** 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.

_____ _____

Patient 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 the Patient:
_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT:

Revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: _____ Date: _____

Financial & Insurance Information

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance with an indemnity/ppo dental carrier with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable deductibles and/or co-insurance which arise during the course of treatment to the patient. The patient and/or responsible party also agree to pay for the treatment rendered to the patient which is not considered to be a covered service by third party insurers or payors.

X_____ _____
Signature Date

My method of payment will be: □ Cash □ Credit Card □ Third Party Financing

Card Credit Card # _____ Exp Date:_____

X_____ _____
Signature Date

If I do not pay the entire new balance within 25 days of the monthly billing date a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies or when there is prepayment for additional services in the case of default on payment of this account. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount of any future outstanding account balances.

RELEASE/STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO PROVIDER

I, (We), the undersigned patient and/or responsible party hereby jointly authorize this office to release and disclose all or any part of the patient's medical records to any entity which is or may be liable for all or party of the provider charges.

I, (We), authorize the release and disclosure of any and all of my medical records to any entity including, but not limited to referring physicians, hospitals, and/or health care providers which may be of assistance in the opinion of this office in providing for the treatment of the patient.

I, (We), authorize the release of records necessary to assist in the reimbursement of benefits to which I, (We) may be entitled. I, (We), authorize this office and/or it's employees to release via fax machine medical records to which are needed in order to provide patient with the most appropriate care.

I, (We), authorize and request that payment of any third party or insurance company benefits be made to this office for any services furnished to patient. The signature below shall suffice for all insurance forms on a continuing basis.

X_____ _____
Signature of patient Date Signature of insured Date