Bienvenido

El privilegio de una sonrisa alegre, saludable es infinito. Nuestro objetivo es ayudarle a lograr y mantener una salud oral óptima. Por favor, sírvase llenar a cabalidad el siguiente cuestionario. Recuerde que establecer una buena comunicación influye en que usted reciba un buen servicio.

Uno Informacion Personal

Fecha: _____

Nombre: _____
Apellido Nombre Inicial Sr. Sra. Srta. Dr.

Prefiero ser llamado: _____ ☐ Hombre ☐ Mujer

Fecha de Nacimiento: __/__/__ Edad: _____ Num. SS: _____

Dirección Residencial: _____
Calle Num. Apt.

_____
Ciudad Estado Código Postal

Estado Civil: _____
☐ Soltero(a) ☐ Casado(a) ☐ Viudo(a) ☐ Separado(a) ☐ Divorciado(a)

Tel. Casa: _____

Casa: _____ Otro Num.: _____

Tel Trabajo: _____ Ext: ____ Num. lic.: _____

Nombre del Patrono: _____

Dirección del Patrono: _____

Tiempo de Permanencia: _____ Ocupación: _____

Indique dónde y cúando es el tiempo más conveniente para hablar con usted.

_____

Indique por quién fue referido para proceder a darle las gracias:

_____

Menciane nombre de otros miembros de su familia atendidos por nosotros:

_____

Nombre de su dentista: anterior/actual: _____
Marque con un Círculo

Fecha de su última visita: _____

Dos Informacion Del Conyuge

Nombre: _____

Nombre del Patrono: _____

Num. de Teléfono del Trabajo: _____ Ext: ____ Num. SS: _____

Fecha de Nacimiento: _____ Num. Lic.: _____

Persona Responsable de esta Cuenta: _____

Num. de Teléfono del Trabajo: _____ Ext: ____ Num. SS: _____

Envíese Cuenta a esta Dirección: _____

Relación: _____ Num. SS: _____

Nombre del Patrono: _____ Num. Lic.: _____

Tres Seguro Dental Primario

Nombre de la Compañía Aseguradora: _____

Dirección de la Compañía Aseguradora: _____

Num. de Teléfono de la Compañía Aseguradora: _____

Num. de Grupo (Plan, Local o Póliza Num.): _____

Nombre del Asegurado: _____ Relación: _____

Fecha de Nacimiento del Asegurado: __/__/__

Num. SS del Asegurado: _____

Nombre del Patrono del Asegurado: _____

Cuatro Seguro Dental Secundario

Nombre de la Compañía Aseguradora: _____

Dirección de la Compañía Aseguradora: _____

Num. de Teléfono de la Compañía Aseguradora: _____

Num. de Grupo (Plan o Num. de Póliza): _____

Nombre del Asegurado: _____ Relación: _____

Fecha de Nacimiento del Asegurado: __/__/__

Num. SS del Asegurado: _____

Nombre del Patrono del Asegurado: _____

En caso de una emergencia ¿hay alguna persona cercana a usted a quien nos podamos dirigir?

Nombre: _____ Relación: _____

Num. Teléfono: _____
CASA TRABAJO

Cinco Historial Medico

¿Tiene Usted un médico? ☐ **Si** ☐ **No**

Nombre del Médico: _____

Num. de Teléfono: _____ Fecha de su última visita: __/__/__

CONTINÚA AL DORSO

Seis HISTORIAL MEDICO *continúa*

Actualmente su salud física es: ☐ Buena ☐ Regular ☐ Pobre

¿Está usted bajo el cuidado de algún médico? ☐ Si ☐ No

Explique, por favor: _____

¿Usa usted algún medicamento por su cuenta? ☐ Si ☐ No

Favor de enumerar: _____

Para Mujeres: ¿ Toma usted píldoras anti-conceptivas? ☐ Si ☐ No

¿Está usted embarazada? ☐ Si ☐ No Num. de Semanas: _____

¿Está usted lactando? ☐ Si ☐ No

¿Ha padecido usted de alguna de las siguientes enfermedades o problemas médicos?

Si	No	Anemia / Tratamiento de Radiación	Si	No	Cirugía de Corazón / Marcapaso
Si	No	Huesos Artificiales / Coyunturas	Si	No	Hemofilia / Sangra con facilidad
Si	No	Válvulas Artificiales	Si	No	Hepatitis
Si	No	Asma / Artritis	Si	No	Presión Arterial Alta / Baja
Si	No	Transfusión de Sangre	Si	No	SIDA / "HIV"
Si	No	Cáncer / Quimioterapia	Si	No	Hospitalizado por alguna razón
Si	No	Defecto Congénito del Corazón	Si	No	Problemas del Riñón
Si	No	Diabetes / Tuberculosis (TB)	Si	No	Prolapso: Válvula Mitral
Si	No	Dificultades Respiratorias	Si	No	Problemas Psiquiátricos
Si	No	Abuso de Drogas / Alcohol	Si	No	Fiebre Reumática / Fiebre Escarlatina
Si	No	Enfisema / Glaucoma	Si	No	Dolores de Cabeza Severos / Frecuentes
Si	No	Epilepsia / Convulsiones / Desmayos	Si	No	Herpes Zoster / Culebrilla
Si	No	Ampollas / Herpes	Si	No	Sinusitis
Si	No	Ataque del Corazón / Derrame	Si	No	Ulceras / Colitis
Si	No	Soplo	Si	No	Enfermedades Venéreas

Por favor, enumere cualquier otra condición médica seria que haya padecido.

_____

_____

¿Es usted alérgico a alguno de los siguientes medicamentos?

Si	No	Anestésico Dental	Si	No	Eritromicina	Si	No	Penicilina
Si	No	Aspirina	Si	No	Latex	Si	No	Tetraciclina
Si	No	Codeína	Si	No	Otros			

Por favor, enumere cualquier otro medicamento al cual sea usted alérgico:

_____

Siete HISTORIAL DENTAL

Razón por la cual visita al dentista hoy: _____

_____

¿Siente dolor? ☐ Si ☐ No ¿Ha tenido problemas serios con algún tratamieto dental previo? ☐ Si ☐ No

¿Ha sentido usted dolor o molestia en la coyuntura temporo mandibular (TMJ, TMD)? ☐ Si ☐ No

Actualmente su salud dental es: ☐ Buena ☐ Regular ☐ Pobre

¿Le gusta su sonrisa? ☐ Si ☐ No ¿Sangran sus encías? ☐ Si ☐ No

¿Cúantas veces al dia usa el hilo dental? _____

¿Cúantas veces al dia se cepilla? _____

¿Tipo de cepillo que usa? ☐ Duro ☐ Mediano ☐ Suave

A mi mejor entender, la información dada hoy es correcta. También entiendo que la misma es confidencial y que es mi responsabilidad notificar a la oficina cambios en mi condición de salud. Autorizo al personal dental a practicar los servicios dentales que sean necesarios para luego de haber sido informado dar mi consentimiento para diagnóstico y tratamiento.

Firma: _____ Fecha: _____

De no haber sido aprobado otro convenio, el total de su cuenta debe ser cubierto al recibir el tratamiento.

Gracias por llenar este cuestionario completamente. El mismo ayudará a servirle efectivamente. Nos complacerá contestar sus preguntas.

Nuestra oficina está comprometida a cumplir o a superar las regulaciones de control de infección según ordenadas por OSHA, CDC y el ADA.

USO OFICIAL USO OFICIAL USO OFICIAL USO OFICIAL USO OFICIAL

Yo he revisado verbalmente la información médica / dental que aparece arriba con el paciente aquí mencionado. Iniciales: _____ Fecha: _____

Comentarios del Dentista: _____

_____

HISTORIAL MEDICO AL DIA

1. Fecha: _____ Comentarios: _____ Firma: _____
2. Fecha: _____ Comentarios: _____ Firma: _____
3. Fecha: _____ Comentarios: _____ Firma: _____

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