ALEXANDER LEYTE-VIDAL, DDS, PA
FAMILY AND COSMETIC DENTISTRY
808 EXECUTIVE DRIVE, OVIEDO, FLORIDA 32765
407-971-4444

PATIENT INFORMATION

Patient Information	Responsible Party/ Guarantor Information
Name:_____	Name:_____
Address: _____	Address: _____
City/State/Zip:_____	City/State/Zip:_____
Date of Birth: _____	Date of Birth: _____
Home #: _____ Cell #: _____	Home #: _____ Cell #: _____
Email: _____	Email: _____
Employer: _____	Employer: _____
Business Address: _____	Business Address: _____
City/State/Zip: _____	City/State/Zip: _____
Business Phone: _____	Business Phone: _____
Occupation: _____	Occupation: _____
Social Security #: _____	Social Security #: _____

Insurance Information

Name of Policy Holder_____ Date of Birth: _____
ID #: _____ Insurance Company: _____ Phone: _____
Employer: _____ Group #: _____

Driver's License #: _____ Marital Status: ☐ S ☐ M ☐ W ☐ D

Sex: ☐ M ☐ F

Family Members at this Office: _____

How Did You Hear About The Office? ☐ Friend/Family ☐ Web ☐ Advertisement

Whom May we Thank? _____

Emergency Information Contact: Name:_____ Phone: _____

Preferred Pharmacy: Phone:

Assignment and Release

I certify that I (or my dependent) have insurance coverage and assign directly to Dr. Leyte-Vidal all insurance benefits, if any, otherwise payable to me for services rendered. I understand that my Dental Insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian: _____ Date: _____

Alexander Leyte-Vidal, DDS, PA
Family and Cosmetic Dentistry
808 Executive Drive, Oviedo, Florida 32765

Financial Policy

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin we would like to highlight a misconception, dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payments.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying you, our patient, with the highest quality of dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should never be governed by your insurance contract.

However, it should be understood that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

We hope that this information has been helpful. Please take time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing and insurance.

Patient/Guardian Signature: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I Acknowledge that I have received a copy of Alexander Leyte-Vidal, DDS, PA **HIPPA Notice Of Privacy Practices.**

Patient Name (print): _____ **Date:** _____

Patient/Guardian Signature: _____
Relationship to patient (if not self): _____

For office use only

We attempted to obtain written acknowledgement of receipt of our notice of privacy Practices, but could not be obtained because:

___Individual refused to sign
___Communications barrier prohibited obtaining the acknowledgement
___An emergency situation prevented us from obtaining acknowledgement
___Other (Specify)_____

Staff Signature:_____ Date: _____

ALEXANDER LEYTE-VIDAL, DDS, PA
FAMILY AND COSMETIC DENTISTRY
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DENTAL HISTORY

Reason for this visit_____
When was your last dental visit? _____
What was done? _____
Previous Dentist: _____
Have you had a complete series of Radiographs/Panoramic taken?_____When? _____

Place a mark if you have had any of the following:

	Y	N
Bad Breath		
Bleeding Gums		
Blisters on lips or mouth		
Burning sensation		
Chew on one side		
Smoking		
Click or Popping Jaw		
Dry Mouth		

	Y	N
Fingernail biting		
Food collection on teeth		
Grinding		
Swollen gums		
Jaw pain		
Lip biting		
Loose teeth		
Broken fillings		

	Y	N
Orthodontic treatment		
Pain around ear		
Periodontal treatment		
Sensitivity to cold		
Sensitivity to heat		
Sensitivity to sweets		
Sensitivity biting		
Sores on the mouth		

How often do you brush?_____

Do you wear dentures? _____ **How old are they?** _____

Do you have dental implants?_____ **Where?** _____

If I could change my smile, I would:

- ☐ **Make them Whiter**
- ☐ **Make them Straighter**
- ☐ **Close spaces**
- ☐ **Replace metal fillings with colored restorations**
- ☐ **Repair chipped teeth**
- ☐ **Replace old crowns that don't match**
- ☐ **Have a smile makeover**

Patient/Guardian Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

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MEDICAL HISTORY

Patient Name:_____

Place a mark if you have had any of the following:

	Y	N
AIDS/HIV		
Allergies (Seasonal)		
Anemia		
Arthritis		
Artificial Heart Valves		
Artificial Joints		
Asthma		
Blood Disease		
Bruise Easily		
Cancer		
Chemotherapy		
Diabetes		
Dizziness		
Drug Addiction		
Emphysema		
Epilepsy		
Excessive Bleeding		
Fainting		
Glaucoma		
Heart Conditions		
Heart Lesions (Congenital)		
Heart Murmur		
Heart Surgery		
Hepatitis A		
Hepatitis B		
Hepatitis C		

	Y	N
High Blood Pressure		
Jaundice		
Joint Pain		
Joint Replacement		
Kidney Disease		
Liver Disease		
Low Blood Pressure		
Mitral Valve Prolapse		
Nervousness/Depression		
Nursing		
Pacemaker		
Pregnant (Currently)		
Psychosis		
Radiation (head/neck area)		
Respiratory Problems		
Rheumatic Fever		
Seizures		
Sore Lymph Nodes		
Stomach Problems		
Stroke		
Thyroid Disease		
Tuberculosis		
Ulcers		
Venereal Diseases		

Other (please specify): _____
_____

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MEDICAL HISTORY

Do you have any of the following drug allergies?

☐ **Aspirin/Ibuprofen** ☐ **Codeine** ☐ **Erythromycin** ☐ **Valium**

☐ **Penicillin** ☐ **Sulfa** ☐ **Local Anesthetic** ☐ **Tetracycline**

☐ **Iodine** ☐ **Epinephrine**

☐ **Other (please specify)** _____

Are you allergic to Latex? ☐ Yes ☐ No

Are you taking Birth Control Pills? ☐ Yes ☐ No

Are you under a Physician's Care? ☐ Yes ☐ No

If yes, What for? _____

Are you taking any medications? ☐ Yes ☐ No

If yes, Which one(s)? _____

_____

Are you taking any herbal supplements? ☐ Yes ☐ No

If yes, which ones? _____

Do you need pre-medication prior to dental appointments? ☐ Yes ☐ No

Physician's Name: _____ Phone: _____

I understand that providing incorrect information can be dangerous to my health.

Patient Signature/Guardian _____ **Date:** _____

Doctor Signature: _____ **Date:** _____