Patient Information Chart # ______

Patient Name: ________________________________ Preferred Name: ______________________

Title: ____ Gender: Male __ Female __ Family Status: [X] Married __ Single __ Child __ Other__

Responsible Party: [X] Self ___ Spouse ___Guardian ___

Birthdate: ___/___/___ Email Address: ______________________________________

Cell/Home Phone: ____________________ Best Time to Call: Morning __ Afternoon __ Night __

Address: ____ Apt/Ste: ______________

City: __________________________________ State: ____ Zip: ______________

Whom may we thank for referring you to the practice? [X]

Dental Office __ Internet __ Postcard __ Walk-In __ Patient Referral __

Name of person, office or other source referring you to the practice:

____

Employment Information

The following is for: [X] The Patient __ The Person Responsible for Payment__

Employer Name: ____ Phone: ___________________

Address: ____ Apt/Ste: ______________

City: __________________________________ State: ____ Zip: ______________

Patient Dental Insurance Information

Name of Insured: __________________________________ Insured Birth Date: ______________

ID#: ________________________ Group Number#: ______________________________

Insured Zip Code: ____________ Insured's Employer Name: ________________________________

Insurance Plan Name: ____

Relationship to Patient: [X] __Self __Spouse __Child __Other

FINANCIAL ARRANGEMENT AND TREATMENT PLAN POLICY

APPOINTMENTS

We have allocated dental staff and resources for your individual dental needs, which will result in a financial loss if you do not call us 24 hours before your appointment to reschedule. In order for us to effectively re-utilize the time with the doctor or hygienist, you will be charged a cancellation fee to reduce the loss the doctor incurs in your absence.
If you miss your dental appointment, or cancel the same day, there is a $25.00 cancellation fee you must pay.

______ *[Please Initial if you understand and comply]*

FEES

Our office fees are based on usual and customary high quality community standards of dental care fee practices. Prices and treatment plans are explained on your initial appointment; a treatment plan is presented for your acceptance and signature, and its acceptance represents a financial commitment on your part.

Please remember that your dental benefits program is a contract between you and your dental insurance company. We expect you to pay any co-payments, deductibles and patient portion of the balance at the time services are rendered. **Treatment plans provided by the office are just an estimate of what your insurance plan covers. In the event that your insurance covers less than the estimate for services rendered, it is your responsibility to pay the difference.**

______ *[Please Initial if you understand and comply]*

You are responsible for any service rendered that is not a covered benefit by your dental insurance.

______ *[Please Initial if you understand and comply]*

PAYMENTS

Payment is expected IN FULL the day services are rendered, and any permanent and removable dental appliances must be paid before delivery. **Our office does not offer payment plans.** However, for your convenience, we provide you with financing options, and our clerical staff will assist you in applying for it, if that is an option you want to consider.

Cash, Visa, MasterCard, Discover Card and financing through Care Credit are the only acceptable payment options. **Personal checks, or American Express are not accepted.** There are NO EXCEPTIONS.

______ *[Please Initial if you understand and comply]*

BALANCE & COLLECTION POLICY

In the event that your insurance does not cover a procedure, it is your responsibility to pay the balance. A copy of your Explanation of Benefits will be sent to your house with a copy of your Statement Balance. You will be sent to the creditors if you fail to pay your balance after 30 days.

______ *[Please Initial if you understand and comply]*

REQUESTS FOR X-RAYS AND DENTAL RECORDS

The radiographs that are taken for the $50 Special are the sole property of Dr. Adriana Mejia's dental office. If you need to remove these x-rays from the dental office, then you will be charged for the radiographs at their full original fee.

If you are an insured patient requiring your radiographs, if your insurance did not cover the x-rays that were taken at the dental office, you are responsible for paying the office for them as well.

You must also sign a consent form to remove the radiographs from the office, and the signature must be done in person. If the radiographs are being sent digitally to another dental office, that dental office must request these radiographs in writing (by fax, on a letterhead) so that we may keep on record that you are continuing with your dental treatment elsewhere. It cannot be faxed or emailed in. There are no exceptions.

______ *[Please Initial if you understand and comply]*

______________________________ ______________________________

Patient or Guardian Signature Date

Medical & Dental History Form

Patient Name: ____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? [X] Yes __ No __

Within the past year, have there been any changes in your general health? Yes __ No __

What is the date of your last medical exam? ______________________________

Your Primary Care Physician's name, address & phone number: ____________________

____

Please mark any of the following to indicate YES in response to the question: [X]

__ Have you ever had complications following dental treatments?

__ Are you currently under the care of a physician due to a specific condition?

__ Have you been hospitalized within the last 5 years due to surgery or illness?

__ Are you currently taking any prescription or non-prescription medications?

__ Do you use tobacco [smoking or chewing]?

__ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the following are marked, please explain: ______________________________

What is the reason for your dental visit today? ______________________________

What was done on your last dental visit [and the date]? ______________________________

Prior Dentist's Name, Address & Phone number: ______________________________

How frequently do you brush your teeth? [X] __ 3+ a Day __ Twice a day __Once a day

Please mark any of the following to indicate YES in response to the question: [X]

__ Do your gums bleed when you floss or brush? __ Are any of your teeth causing you pain?

__ Do your teeth experience sensitivity due to cold/hot? __ Do you grind your teeth?

__ Are any of your teeth loose, or are you concerned about any teeth loosening?

__Do you currently have any dental implants, dentures, or partials?

WOMEN ONLY: Are you pregnant? [X] __ Yes __No When is the due date: __________

PLEASE MARK IF ANY OF THE FOLLOWING APPLY:

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Birth Control
- [ ] Blood Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Mental Disorders
- [ ] Mitro Valve Prolapse
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Authorization

I hereby certify that I have read and understood the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent[s] to third-party insurance carriers, payors and/or health practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf of my dependents [if any].

Signature of patient, parent or guardian: ______________________ **Date:** ______________

CONSENT FOR LOCAL ANESTHETIC INJECTIONS

I, ______________________________, hereby authorize any Board Certified Dentist at **Adriana Mejia, DDS, P.A.'s** dental practice, to administer local anesthetic injection(s).

I understand and it has been explained to me, that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection, which cannot be determined before the administration of the anesthetic agent. Although the risks seldom occur, they might include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs it is often temporary and normal sensation usually return in several days. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as anesthetic agent may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

On the other hand, I understand that there are some medications that may cause interactions (give a reaction) to local anesthetic. Therefore, **it is my responsibility to inform the dentist of any medication I may be taking for any other medical conditions; including over the counter medication, recreational drugs and any other substance such as a health supplement that may not be considered "drug."** I further understand that individual reaction cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the office as soon as possible.

Further, I have been explained that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instruction, taking prescribed medications and reporting to the office any change in my health status.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I have discussed all of the above with the doctor, and I had all of my questions answered.

______________________________ ______________________________

Patients Signature **If a minor, signature of parent**

DATE:________________

Translated by:

______________________________ ______________________________

Witness Signature Dentist/ Signature

Notice of Privacy Practices
(Dental)

This Notice Describes how medical information about you may be used and disclosed and how you can get access to the information.
Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by HIPPA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclosure your health information. *Such as Treatments, Payments, Health Care Operations.* We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of *April 27, 2006.* And we are required to abide by the terms of Notice of Privacy Practices currently in effect. We reserve the right to change the terms our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with your office, or the Department of Health & Human Resources, Office of Civil Rights, about violations of the provisions of this office notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S. W.
Washington, D.C. 20201
(202)-619-0527 or Toll Free: (877)-696-6775

I understand Dr. Adriana Mejia DDS PA is required by law to maintain the privacy of my protected health information and they can, at any time, provide me with a copy of my signed notice of their legal duties and practices with respect to their HIPPA compliance and those provisions .

_______________________________ ____/____/______

Patient Signature Date