Cheer Dental - Dr. Patricia Guerra-Hirji

Patient Registration Form- Please complete all the information that applies to you

Patient Last Name:_____ _____First:_____ Initial:_____
How do you wish to be address?_____DOB_____
☐ Single ☐ Married ☐ Divorced ☐ M☐ F Full Time Student: Y N School:_____
Home Address_____
_____
Telephone #(mobile)_____Work#_____Home #_____
Email_____
Employer_____Occupation_____

Guarantor-Person who holds insurance

Dental Insurance ID #_____ Dental Ins. Phone #_____
Dental Insurance Co._____ Soc. Sec. No._____ Group:_____
Is Patient covered by any other insurance? Y N Ins. Company:_____
How did you hear about our practice? _____
Whom may we thank for your referral _____
Appointments Reminder: ☐ Phone Call ☐ Text ☐ Email

Husband, Father or Responsible Party

Last Name:_____ FIRST:_____ INITIAL:_____
Adress_____
_____DOB_____
Telephone (mobile)_____Work_____
Email_____
Employer_____Occupation_____
Dental Insurance Co._____ Soc. Sec. No._____

Wife, Mother or Responsible Party

Last Name:_____ FIRST:_____ INITIAL:_____
Address_____
_____DOB_____
Telephone (mobile)_____Work_____
Email_____
Employer_____Occupation_____
Dental Insurance Co._____ Soc. Sec. No._____

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims to the insurance company.
I hereby authorize payment of insurance benefits directly to the dentist or dental group. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and I agree to be responsible for payments of services not paid in whole or in part by my dental care payer.
I attest to the accuracy of the information on this page.

Signature:_____ Date_____

Medical Health History- Please Complete all information

Patient Name:_____Date:_____

Medical History

Physician's Name:_____ Phone Number: _____
Date of Last Visit:_____

Have you had any serious illness or operations: ☐ no ☐ yes, please explain _____

Have you ever had a blood transfusion: ☐ no ☐ yes, give approximate dates_____

Women: Are you pregnant: ☐ no ☐yes Months: _____Nursing_____ Birth Control Meds_____

Please Circle if you have or had:

- Allergies, Hay Fever, Sinusitis
- Artificial Heart Valves
- Sinus Trouble
- Arthritis, Rheumatism
- Asthma, Date of last attack_____
- Required Hospitalization
- High Cholesterol
- Used Steroids
- Pacemaker
- Skin Rash
- Bleeding abnormally w/operation and surgery
- Blood Disease, clotting disorder
- Mood Swings
- Circulatory problems
- Slow Healing Wounds
- Anemia
- Sickle Cell Anemia
- Cancer
- Chemotherapy
- Radiation

ADHD
Herpes
Heart Murmur
Heart Problems
High Blood Pressure
Low Blood Pressure
Venereal Disease----------
Fainting
Kidney Disease
Stroke
Swelling of feet and ankles
Transplant----------
Shortness of Breath
Epilepsy or Seizures
Diabetes
Glaucoma
Osteoporosis
Artificial Joints
Cortisone Treatment
Weight Loss Unexplained

Depression
Anxiety
Tumor or Growth on ------
Acid Reflux
Stomach Ulcers
Arrhythmia

Any Immune Deficiency
Thyroid Problems

Cough, persistent or bloody
Emphysema
Respiratory Disease
Tuberculosis
Liver Disease
Hepatitis, Type_____
Jaundice

Any other Medical condition not listed above?_____

Are you allergic to Latex, any medications, or metals? Please List_____

Have you taken any osteoporosis medications in the last 3 yrs? Yes No

Please List all Medications that you are currently taking:

Authorization and Release

I have read and truthfully answered the above questions to the best of my knowledge.
Patient/Guardian Signature_____ Date_____

Doctor's Signature:_____Date:_____

Dental Health History

Patient Name:_____Date:_____

Please Complete all information

Dental History

Reason for your visit today_____ _____

Date of last dental visit:_____
Date of last dental x-rays:_____

Please Circle if you have/had:

Bad Breath	**Head/Neck/ Jaw Pain**	**Orthodontic Treatment**	**Cigarette/Pipe Smoking**
Dry Mouth	**Clench or Grind your teeth**	**Periodontal Treatment**	**Smokeless Tobacco**
Mouth Breathing	**Broken fillings**	**Nitrous Oxide**	
Gums swollen, tender, or bleeding	**Loose Teeth**	**Jaw Surgery**	
Food collection between teeth	**Sensitivity: Generalized or Localized**		
How often do you brush?			
How often do you floss?			

Have you ever had trouble from previous dental care? No Yes, please Explain:

_____ _____

Have you ever had any allergic reaction to Local Anesthetics? No Yes, please Explain

_____

Are there any other conditions the doctor should be aware of? No, Yes, Please Explain

Authorization and Release

I have read and truthfully answered the above questions to the best of my knowledge.

Patient/Guardian Signature_____ Date_____

Doctor's Signature:_____Date:_____

Cheer Dental Financial Policy

Patient Name:_____Date:_____

Dr. Patricia Guerra- Hirji is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **All patients must complete our "Patient information form" before seeing the dental professional**
- **Full payment is due at the time of services**
- **We accept Cash, Visa, MasterCard, and Care Credit. WE DO NOT ACCEPT CHECKS**
- **We provide insurance billing as a courtesy to our patients. The patient portion for a particular dental service(s) is estimated and due at the time of services.**

ADULT PATIENTS

Adult patients are responsible for full payment at the time of services.

MINOR ACCOMPANIED BY ADULT

The adult accompanying a minor, his/her parents or guardians are responsible for full payment at the time of services

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at the time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, Master card, or Care Credit.

INSURANCE

We provide insurance billing as a courtesy to our patients. The patient portion of a particular dental service is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s), claim (s) is adjudicated by the insurance company. In addition, certain insurance companies have annual limitations for the amount of dental services that can be reimbursed within each year plan. If you or your family exceed this annual limitation in any plan year, you would be responsible for the amounts not covered. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. **The patient may not rely on upon any information provided by the staff regarding his/her remaining benefit in any such benefit period**.

The claims we submit to insurance company indicate that you have assigned those benefits to us. However, if you are paid by the insurance company by error, you are then responsible for the total account balance ad payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. We will collect coinsurance and deductibles based on your primary insurance, file your secondary insurance, and have their payment from the secondary insurance go directly to you.

The patient/ responsible party are always fully responsible for any charges that are not covered by your insurance.

MEDICAID/MEDICARE/WORKER'S COPENSATION

If you are covered by Medicaid, Medicare, Worker's Compensation, or any other government sponsored program, Please discuss your payment situation with our office staff prior to your appointment.

DELINQUENT PAYMENTS

It is our policy to charge 1.5% for outstanding patient balances after 30 days.

MISSED APPOITMENTS

Our office will reserve the doctor's time only for you. **Unless cancelled at least 48 hours in advanced, our policy is to charge for missed appointments $35.00 for each 35min of missed appointment time**. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature: _____Date:_____

Consent for use and disclosure of health information and contractual assignment of Benefits

Section A: Confidential Agreement.

Name:_____SS#:_____

Section B: Please Read the following statements carefully

Purpose of this Consent: By signing this form you will consent to our use of disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

☐ I hereby assign by benefits contractually to Cheer Dental

☐ I authorize release of my information to all insurance carriers

☐ I authorize my doctor and Cheer Dental to contact my employer and insurance carrier for information and to act as my agent to obtain payment from my insurance carries and/or employer

☐ I authorize payment directly to my doctor

☐ I permit a copy of the authorization to be used in placed of the original

☐ I hereby certified that I don't have any other insurance coverage

Notice of Private Practice: You have the right to read the Notice of Private Practice before you decide whether to sign this consent. Our notice describes our treatment, payment activities, and healthcare operations of the uses of disclosures we may make of your protected health information. A copy of our notice accompanies this Consent and is posted in the reception area. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our private practices as described in or Notice of Private Practices. In that event, we will issue a revised Notice of Private Practices which will contain the changes. Those changes will apply to all your protected health information that we maintain.

You may obtain a copy at any time upon request.

Right to Revoke: You will have the right to revoke this consent at any time by giving written notice. Please understand that revocation of your consent will not affect any action we took before we received your revocation.

Section C: Signature

I,_____ have had the opportunity to read and consider the contents of this Consent form and Notice of Private Practices. I understand that by signing, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following

Personal representative's Name:_____

Relationship to Patient:_____

Section D: Patient/Relative HIPAA Consent:

I,_____ understand that by signing the Consent form, I am giving consent to Cheer Dental to discuss and disclose any protected health information to carry out treatment, payment activities, and health care operations with the following member.

Name: _____ __ Relationship:_____

Name: _____ __ Relationship:_____

Name: _____ __ Relationship:_____

_____No one other than myself

Right to Revoke: You have the right to revoke this consent at any time by written notice of your revocation.

_____ _____

Patient's Signature: (Legal Guardian if Patient is a Minor) Date

Section E: Patient Record

I wish to be contacted in the following matter:

By: cell phone. My Number is:_____

____It is ok to leave me a message with detailed information

____It is NOT ok to leave me a message with detailed information

By email: My email is:_____

____It is ok to send detailed information

____It is NOT ok to send detailed information

Section F: Revocation of Consent

I 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 continue to treat e after I have revoked this Consent

Signature:_____ Date:_____

If this revocation of *Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following*

Personal representative's Name:_____

Relationship to Patient:_____

Medical Health History Updates

Patient Name: _____

I have read my medical History and confirm that I adequately states past and present conditions.

Date	Changes	Patient Initials	Doctor Initials
_____	_____	_____	_____