Patient ,Pharmacy and Insurance Information

Patient Name :______________________ Date of Birth:__________ Sex: M F
Address:______________________ Zip Code :________City______________State:______
Social Security # :______________________ Marital Status: S M D W
Preferred Phone# :______________________ Is this a mobile number YES / NO
Email address:______________________

Emergency contact:______________________ Phone number :______________Relationship:______

Preferred Pharmacy

Name:______________________ Phone Number: ______________________
Address :______________________ Zip Code:______ City:__________State :____

Primary Dental Insurance

Is the subscriber the patient? Yes / NO
Subscriber Information:
First Name :______________ Last Name:______________ Date of Birth:__________
Employer Name :______________________ Insurance Company:______________
Ins Phone number:____________ Subscriber ID/:____________ Group Number:__________
Relationship to subscriber:______________________ Subscriber phone #______________________

Secondary Dental Insurance: (if no secondary coverage, leave blank)
Is the subscriber the patient? Yes / NO
Subscriber Information:
First Name :______________ Last Name:______________ Date of Birth:__________
Employer Name :______________________ Insurance Company:______________
Ins Phone number:____________ Subscriber ID/:____________ Group Number:__________
Relationship to subscriber:______________________ Subscriber phone #______________________

Assignment and Release

I certify that I and/ or my dependent(s), have insurance coverage with the above named Insurance Company and assign Katyleydis Del Pino Caro of Alamo City Family Dentistry all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dental facility may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will stay in effect as long as I am a patient with the above named dental facility.

Signature of Patient or Responsible Party:______________________ Date:______________

HEALTH HISTORY

Patient Name: ______________________ Date: ______________

Have you been or are you now under a physician's care? Yes No
If yes, why? ______________________

Have you ever been hospitalized? Yes No
Reason: ______________________

Physician's Name: ______________________

When was your last complete physical? ______________________

Are you currently taking any medications? Yes No
List: ______________________

Have you taken any cortisone/had steroid therapy during the past two years? Yes No

Are you allergic to or have any adverse reaction to any of the following medications?

Aspirin	Codeine	Penicillin
Erythromycin	Local Anesthetic	Nitrous Oxide

Are you aware of being allergic to any mediations? Yes No
If yes, please list: ______________________

Do you have or have you had any of the following:

Artificial Joint	Yes	No	Anemia	Yes	No
Heart Valve Implant	Yes	No	Blood Transfusion	Yes	No
Heart Disease/Attack	Yes	No	Hepatitis/Jaundice/Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No	AIDS/HIV Exposure	Yes	No
High/Low Blood Pressure	Yes	No	Venereal Disease	Yes	No
Pacemaker	Yes	No	Alcoholism/Drug Abuse	Yes	No
Allergies/Asthma	Yes	No	Radiation Treatment	Yes	No
Sinus Problems	Yes	No	Cancer/Tumor	Yes	No
Epilepsy/seizures	Yes	No	Chemotherapy	Yes	No
Fainting/Dizzy Spells	Yes	No	Malignant Hyperthermia/Family History	Yes	No
Psychiatric Treatment	Yes	No	Ulcers	Yes	No
Glaucoma	Yes	No	Nervous Problems	Yes	No
Diabetes	Yes	No	Recent Weight Loss	Yes	No
Eating Disorder	Yes	No	Blood Diseases	Yes	No
Circulatory Problems	Yes	No	Arthritis	Yes	No
Excessive Bleeding from Cut/Injury	Yes	No	Stroke	Yes	No

Do you smoke or chew tobacco? Yes No
How much? ______________________

Do you consume alcoholic beverages? Yes No
How often? ______________________

Are you pregnant or suspect you may be? Yes No
Are you nursing Yes No
Are you taking oral contraceptives? Yes No
Do you wear contact lenses? Yes No
Do you have any disease, condition or problem not listed? Yes No

To the very best of my knowledge, the above information is true Yes No

Patient Signature ______________________ Date ______________

Staff Signature ______________________ Dr. Initial ______________

Financial Policy

Thank you for choosing Alamo City Family Dentistry as your dental provider. We are committed to your (or your child's) treatment being successful and pleasant. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we ask that you read and sign prior to treatment. All must complete our information forms before seeing the Doctor.

WE ACCEPT CASH,CHECKS, DEBIT/CREDIT CARDS, AND CARECREDIT.
THERE WILL BE A $25.00 CHARGE ON RETURNED CHECKS.

Regarding Insurance
The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you provide your complete insurance information. **Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.** Please understand there are many different insurance plans. As a courtesy to you, our staff spends a great deal of time getting information and benefits.We do the best we can with the information the insurance company provides. **This is not a guarantee of payment . Payment is determined at the time the claim is received by the insurance company.** If your insurance company has not paid your account in full within 60 days of the claim being processed, the remaining balance will be a total of your non-covered services and any patient portion that was not collected at the time service rendered. We will notify you of any balance for which you are responsible and if payment arrangements have not been made, your account will be referred for collection.

ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

In the event that your insurance coverage changes, our office must be notified at least 2 business days prior to the appointment to ensure proper verification. If for some reason we are not notified in advance, we cannot accurately predict insurance company procedure coverage.

The adult accompanying a minor and the parents/guardians are responsible for full payment.

Broken Appointments / No Show Policy

Appointment times are reserved exclusively for you. We do not double book. Time lost is costly to everyone.We reserve the right to charge for broken appointments.If you are unable to make your appointment, please call us within 48 hours to reschedule. If you do not call, text, leave a voicemail and you do not show up, you will be charged a $35.00 no-show fee. Thank you for your cooperation and we look forward to a mutually satisfying relationship. Please feel free to discuss your particular needs with the staff.

I HAVE READ THE ABOVE AND AGREE TO THE TERMS, I authorize release of any information relating to my insurance claims and the assignment of any and all dental benefits paid directly to Katyleydis Del Pino Caro of Alamo City Family Dentistry of the group benefits otherwise payable to me.

________________________________ __________________________

Patient (Parent/ Guardian) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, ________________________________, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

{Please Print Name}	Relationship
{Please Print Name}	Relationship
{Please Print Name}	Relationship

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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DENTAL QUESTIONAIRE: Please answer to help us serve you

1.) When was your last exam? ____________________________

2.) When was your last cleaning? __________________________

3.) Are you having pain or discomfort at this time? YES NO

4.) Do your gums bleed when you brush? YES NO

5.) Are you happy with your smile? YES NO

6.) Are you interested in whitening your teeth? YES NO

7.) Are you interested in straightening your teeth? YES NO

8.) Are you interested in invisible braces? YES NO

9.) Have you been told you grind your teeth at night? YES NO

10.) Have you been diagnosed with TMJ problems? YES NO

11.) Are you concerned with bad breath? YES NO

12.) Are you frequently experiencing a dry mouth? YES NO

Comments____