Demographics

AMISTAD DENTISTRY
COSMETIC, IMPLANTS & ORTHODONTICS

First Name: _____ Last Name: _____ Gender: M / F
What name does the patient prefer to go by? _____
Birth Date: _____ SSN: _____ Email Address: _____
Phone Number: _____ Type (*please circle one*): Cell / Home / Work
Address Line 1: _____
Address Line 2: _____
City: _____ State: _____ Postal Code: _____

Who is filling out the form today? Please provide your first and last name:
First Name: _____ Last Name: _____
Phone Number: _____
Who has legal custody of the patient?: _____

Primary Contact Details - who should we contact for scheduling?
Primary Contact Name: _____
Relationship to Patient: _____
Phone Number: _____ Type (*please circle one*): Cell / Home / Work
Address Line 1: _____
Address Line 2: _____
City: _____ State: _____ Postal Code: _____

How did you hear about us?: _____

RESPONSIBLE PARTY / GUARANTOR INFORMATION

Is the patient also the guarantor? Yes / No
Guarantor First Name: _____ Guarantor Last Name: _____
Relationship to Patient: _____
Phone Number: _____
Address Line 1: _____
Address Line 2: _____
City: _____ State: _____ Postal Code: _____

EMPLOYMENT DETAILS

Occupation: _____ How long?: _____
Employer Name: _____
Please list 2 contact names to whom practice can release PHI information (HIPAA)
First Name: _____ Last Name: _____ Phone Number: _____
First Name: _____ Last Name: _____ Phone Number: _____

EMERGENCY CONTACT

First Name: _____ Last Name: _____ Phone Number: _____

Signature _____

AMISTAD DENTISTRY
COSMETIC, IMPLANTS & ORTHODONTICS

Dental Insurance

Do you have dental insurance? Yes / No

Name of Insured: _____ Insured's Birth Date: _____

Insured's Address Line 1: _____

Insured's Address Line 2: _____

Insured's City: _____ Insured's State: _____ Insured's Postal Code: _____

Patient's Relationship to Insured: _____

Insured's Employer Name: _____

Employer's Address Line 1: _____

Employer's Address Line 2: _____

Employer's City: _____ Employer's State: _____ Employer's Postal Code: _____

Carrier Name: _____

Plan Name: _____

ID #: _____ Group #: _____

Insurance Company Phone Number: _____

Insurance's Address Line 1: _____

Insurance's Address Line 2: _____

Insurance's City: _____ Insurance's State: _____ Insurance's Postal Code: _____

Do you have Secondary Insurance? Yes / No

Name of Insured: _____ Insured's Birth Date: _____

Insured's Address Line 1: _____

Insured's Address Line 2: _____

Insured's City: _____ Insured's State: _____ Insured's Postal Code: _____

Patient's Relationship to Insured: _____

Insured's Employer Name: _____

Employer's Address Line 1: _____

Employer's Address Line 2: _____

Employer's City: _____ Employer's State: _____ Employer's Postal Code: _____

Carrier Name: _____

Plan Name: _____

ID #: _____ Group #: _____

Insurance Company Phone Number: _____

Insurance's Address Line 1: _____

Insurance's Address Line 2: _____

Insurance's City: _____ Insurance's State: _____ Insurance's Postal Code: _____

Signature _____

Dental History

AMISTAD DENTISTRY
COSMETIC, IMPLANTS & ORTHODONTICS

Is the patient a minor? Yes / No
Is this your child's first dentist visit? Yes / No

Please provide the following provider details:
Provider Name: _____ Provider Phone Number: _____

Does your child have any of the following?

NO ? YES Cavities / Decay
NO ? YES Lip Sucking / Biting
NO ? YES Speech Problems
NO ? YES Nail Biting
NO ? YES Pacifier / Thumb / Finger Sucking
NO ? YES Mouth Breathing
NO ? YES Tongue Thrust
NO ? YES Nursing / Bottle Habits
NO ? YES Jaw Problems
NO ? YES Grinding Teeth
NO ? YES Has the patient ever had orthodontic treatment (Braces)?
NO ? YES Has the patient ever had any pain/tenderness in their jaw joint (TMJ/TMD)?

Reason for visit: _____
Date of last dental visit: _____ Date of last dental X-rays: _____
How often do you floss?: _____ How often do you brush?: _____

NO ? YES Bad Breath
NO ? YES Bleeding, Red, Swollen Gums
NO ? YES Broken/Loose teeth or fillings**?**Clicking or popping jaw
NO ? YES Grinding teeth
NO ? YES Pain around ear/side of face
NO ? YES Sores/Blisters in mouth

List any other dental concerns/pain:
What did you like the most about your previous dental office?:
What did you like the least about your previous dental office?:
NO ? YES Are you interested in whitening your smile?
NO ? YES Are you happy with your smile? If not, what would you change?:

Signature _____

Medical History

AMISTAD DENTISTRY
COSMETIC, IMPLANTS & ORTHODONTICS

NO ? YES Allergy – Aspirin
NO ? YES Allergy – Codeine
NO ? YES Allergy – Latex
NO ? YES Allergy - Local Anesthetic
NO ? YES Allergy – Penicillin
NO ? YES Allergy – Sulfa

List any other allergies: _____

NO ? YES Abnormal (High/Low) Blood Pressure
NO ? YES AIDS/HIV
NO ? YES Anemia / Bleeding Problems
NO ? YES Artificial Heart Valves
NO ? YES Blood Disease
NO ? YES Congenital Heart Lesions
NO ? YES Heart Problems
NO ? YES Pacemaker

NO ? YES Arthritis / Rheumatism / Gout
NO ? YES Artificial Joints / Bones
NO ? YES Asthma
NO ? YES Cancer
NO ? YES Chemotherapy
NO ? YES Diabetes
NO ? YES Emphysema
NO ? YES Glaucoma
NO ? YES Radiation Treatment (Xray/Cobalt)
NO ? YES Shortness of Breath (Breathing Problems)
NO ? YES Sinus Trouble
NO ? YES Stroke
NO ? YES Thyroid Problems
NO ? YES Tuberculosis
NO ? YES Tumor / growth on head / neck
NO ? YES Ulcer
NO ? YES Epilepsy
NO ? YES Fainting / Dizziness
NO ? YES Headaches (Frequent)
NO ? YES Hepatitis
NO ? YES Herpes
NO ? YES Kidney Disease
NO ? YES Liver Disease
NO ? YES Nervous Problems
NO ? YES Psychiatric Care

List any other medical issues you have: _____

List any serious Illnesses / surgeries / hospitalizations: _____

NO ? YES Are you taking any medications? **(Required)**
List medications you are taking: _____

NO ? YES Do you Smoke?
NO ? YES Do you drink Alcohol?
NO ? YES High Sugar intake?
NO ? YES Pregnant
NO ? YES Nursing

NO ? YES Is the patient under the care of a physician?
Physician Name: _____ Physician Phone Number: _____

NO ? YES Has the patient ever been hospitalized?
Please state the reason for hospitalization: _____
_____

NO ? YES Is the patient physically, mentally or emotionally impaired?
Describe the patient's current physical health (circle one): Poor Fair Good

Signature _____

COVID-19 Screening

AMISTAD DENTISTRY
COSMETIC, IMPLANTS & ORTHODONTICS

NO ? YES Do you have a fever or have you felt hot or feverish recently (14-21 days)?
NO ? YES Are you having shortness of breath or other difficulties breathing?
NO ? YES Do you have a cough?
NO ? YES Do you have any flu-like symptoms, such as gastrointestinal upset, headache or fatigue?
NO ? YES Have you experienced recent loss of taste or smell?
NO ? YES Have you had any contact with any confirmed COVID-19 positive patients?
NO ? YES Is your age over 60?
NO ? YES Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?
NO ? YES Have you traveled in the past 14 days to any regions affected by COVID-19?

Signature _____

Dental Practice Financial Policy

AMISTAD DENTISTRY
COSMETIC, IMPLANTS & ORTHODONTICS

The practice depends upon reimbursement from patients for the costs incurred in their care.

Financial responsibility on the part of each patient must be determined before treatment.

As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

Signature _____

AMISTAD DENTISTRY
COSMETIC, IMPLANTS & ORTHODONTICS

X-rays and Insurance Coverage

We will recommend that certain x-rays be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.

_____

Signature

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received and read your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Signature

Photo Consent

_____ Amistad Dentistry has my permission to use my or my child's photograph publicly to promote the organization. I understand that the images may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

_____ Amistad Dentistry **does not have my permission** to use my or my child's photograph publicly to promote the organization.

_____

Signature