Patient Registration And Medical History

Date: ______________ PLEASE PRINT

Patient: ____
Last Name First Name Middle Name Preferred Name

Street Address ________________________ City ____________ State ________ Zip ________

Email: ________________________ Cell Phone ( ) ____________ Home Ph ( ) ____________

Sex ☐M ☐F Age______ Birthdate____________ ☐Married ☐Single ☐Minor ☐Separated ☐Divorced

Driver License # ________________________ ☐ Partnered for ______ years

Employer/School ________________________ Occupation ________________________

Employer Address ________________________ Work Ph ( ) ________________________

Spouse/Parent Name ________________________ Spouse/ Parent Birthdate ________________________

Social Security # ________________________ Spouse/Parent's Social Security # ________________________

Name of Dental Insurance ________________________ ID# ____________ Group# ____________

In case of emergency, who should be notified? (Name and Ph#) ________________________

Whom may we thank for referring you? ________________________

MEDICAL HISTORY

Please check any of the following that apply to you: Past or present

- ☐ AIDS
- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Endocarditis
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Lesions (Congenital)
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A, B or C (Circle one)
- ☐ High/Low Blood Pressure (Circle One)
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Jaw Joint Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolaspse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Phen Fen (1 month +)
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures/Epilepsy
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Neck Gland
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Diseases
- ☐ Other

Do you have any of the following drug allergies?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Valium
- ☐ Nitrous Oxide
- ☐ Tetracycline
- ☐ Latex
- ☐ Erythromycin
- ☐ Local Anesthetic
- ☐ Other: ________________

Patient/Guardian Signature: ________________________ **Date:** ____________

- Next -

Are you under a physician's care? What for?

____

____

General Physician's Name: ______________________ **Ph #** ______________

Are you taking any medications? YES / NO
If Yes, please list all:

____

____

____

Pharmacy Name ______________________ **Ph #** ______________

Women – Do you suspect that you are pregnant? ☐Yes ☐No Due date: ___________
Are you taking birth control pills? ☐Yes ☐No Are you nursing? ☐Yes ☐No

DENTAL HISTORY

Please check any of the following problems that apply to you.

☐Sensitivity (Hot, Cold, Sweet)
Where? Upper Right or Left
Lower Right or Left
☐Headaches, ear aches, neck pain
☐Do you snore or suffer from a sleep disorder?
____

☐Teeth or fillings breaking
☐Grinding or clenching
☐Bleeding, swollen or irritated gums
☐Loose, tipped or shifting teeth
☐Bad breath

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

☐Dentures ☐Partials ☐Implants
☐Braces ☐Periodontal(Gum) treatments

Please share the following dates:

Your last cleaning ________/_______
Your last oral cancer screening ________/______
Your last complete set of X-rays ______/_______

Name of Previous Dentist ______________________
City________________ State________
Phone # ________________________
Why did you leave your previous dentist?

____

____

If you could whiten your teeth for a cost anyone could afford, would you do it? Yes/No

Do you smoke or use chewing tobacco?
How much? ___________ For how long? _____
Do you drink alcohol? YES/NO
How often? None/ Social/ Daily

If I could change my smile, I would:

☐Make them whiter
☐Make them straighter
☐Close spaces
☐Replace metal fillings with tooth colored ones
☐Repair chipped teeth
☐Replace missing teeth
☐Replace old crowns that don't match
☐Have a smile makeover

On a scale of 1-10, with 10 being the highest:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10
What is the most important thing to you about your dental visit today? ______________

____

____

____

FINANCIAL POLICY

Payment Options:

For your convenience we accept cash, checks, debit cards, Visa, MasterCard, Discover and American Express for payment.

Patients without insurance are expected to pay in full at the time of service.

Patients with insurance are expected to pay all deductibles and percentages not paid by the insurance company at the time of service. The patient is financially responsible to pay the full fee, regardless of insurance payment.

______ **(Initial please)** I understand that Dr. de la Torre **is not an "in-net work" dentist for any insurance with the exception of Delta PPO.**

Payment Plan: *Care Credit* offers interest free payment plans for 6 or 12months. See contracts for details.

Please Note and <u>initial items below</u>:

- ________ Balances older than 90 days are subject to interest charges of 1.5% per month (18% annually).
- ________ Returned checks are subject to a $25.00 charge.
- ________ **24 hours** notice is required to change any appointment. We reserve the right to charge $50.00 per hour cancellation fee if notice is not given.

I, ______________________________, have read, understood and agree to abide by the terms above.

Date: _____/_____/_____ Patient's Signature: ______________________________

Parent or Responsible Party: ______________________ Relationship to Patient: ________

Alina de la Torre, D.M.D.
10830 Sheldon Road - Tampa FL 33626 - 813.792.9400

Assignment of Benefits Form

(Must be filled out for all patients who have dental insurance)

If you have dental insurance or are the policy holder of your family's dental insurance, you need to sign this form. By doing so you are:

- Giving permission for your spouse or children to use your dental insurance at our office.
- Giving permission for us to file dental claims for you, your spouse or dependents, and share information with your dental insurance for the claims to be processed.
- Giving permission for your insurance company to pay us directly.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Alina de la Torre medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Alina de la Torre to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have requested medical services from Dr. Alina de la Torre on behalf of myself and/or my dependents.

____

On the line above-List all family members **including yourself** who you authorize to use your insurance)

____

On the line above-Print the Name of the Policy Holder for the insurance company

______________________________ ______________

Signature of Policy Holder's Name **Date**

______________________________ ______________

Witness Date

Alina de la Torre, D.M.D.

10830 Sheldon Rd. Tampa FL 33626 813-792-9400

Patient Consent & Authorization for E-mail Communication

We find that many patients like us to e-mail them information rather than using traditional mail. Please sign below if we have your permission to communicate with you using e-mail. This may include estimates, dental insurance information or questions/answers about treatment or appointments. If you choose not to sign below, we will mail you the requested or needed information.

E-mail address: ____

Signature: ______________________________ Date: ________________

Name of Patient (please print): ________________________________

Relationship to Patient: __________________

Alina de la Torre, D.M.D.
10830 Sheldon Road - Tampa FL 33626 - 813.792.9400

Patient Acknowledgment of Receipt of Privacy Practices Notice

I, ______________________________, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining:

1. How this office will use and disclose my protected health information.
2. My privacy rights with regard to my protected health information.
3. This office's obligations concerning the use and disclosure of my health information.

I understand that the Privacy Practices Notice may be revised from time to time and that I am entitled to receive a copy of any revised Privacy Practices Notice upon request.

I also understand that if I have any questions, I may contact:

Alina de la Torre, DMD
10830 Sheldon Road
Tampa, FL 33626
(813) 792-9400

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient, Parent or Personal Representative:

Patient Name: ____
Signature: ____ Date: __________________
Name of Parent/Representative if applicable (please print): ________________________________
Relationship to Patient: ____

For Office Use Only

We made an effort to obtain an acknowledgement of ______________________________'s receipt of our Privacy Practices. In spite of our efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons:

1. Patient refused to sign and date _______________.
2. Communication barriers prohibited obtaining acknowledgment.
3. An emergency situation prevented us from obtaining acknowledgment.
4. Other: ____.

Attempt was made by: ______________________________ Date: ____________________

Patient Consent & Authorization for Release of Protected Health Information

Patient Name: ______________________________ Date of Birth: ______________
Address: ____
City: ______________ State: _____ ZIP Code: ________ Telephone : ______________
Email Address: ____

Patient Authorization:

I, ____________________, authorize the release, use, and disclosure of my health information as follows: This authorization pertains to the following type of medical information about me:
Initial all that applies
_____ Any & All _____ Billing only ____ Dental/Medical Information **or Other** -Please list below

____

I authorize Alina de la Torre, DMD, to release the information as described above **to**

____.

Name of person and/or company receiving this information. **Write in above the name of the person(s) we are allowed to share this information with. (Ex: Name of spouse, family member or friend)**

I understand that this authorization will permit the above named parties to use or disclose the identified health information for purposes beyond treatment, payment or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I understand that I may revoke this authorization at any time by providing written notification to Alina de la Torre, DMD.

The revocation of this authorization will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation doesn't apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this form in order to receive treatment, payment, or to enroll or be eligible for benefits.

Unless I request in writing, I understand that this authorization will expire on 12/31/2022 **or** I choose this date for this authorization to expire on ___________(choose date).

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Personal Representative
Signature: ______________________________ Date: ______________
Name (please print): ____
Relationship to Patient: ____

For **Office Use Only**
Received by: ______________________________ Date: ______________

LIMITED DENTAL WARRANTY

Our practice is proud of the dentistry that we provide for you and your family. The long-term success of the dental treatment we provide for you depends upon your commitment to home care of your teeth and gums, regular professional examinations and cleanings. Individuals vary in how often cleanings are needed. **Cleanings may be recommended every 3, 4 or 6 months, depending upon your individual oral health needs.**

DENTAL SEALANTS:

Sealants are plastic coatings placed on the chewing surface of the teeth to help prevent decay in the pits, fissures and grooves of the teeth. Floss and the use of Fluoride will help prevent decay between the teeth. We will replace sealants for a period of **3 years** after initial placement by our office. **You must keep the prescribed regular exam and cleaning appointments or this warranty is null and void (minimum every 6 months).**

FILLINGS:

If a filling restoration is the recommended treatment of choice, we will replace or repair it in the event of failure for a period of **2 years**. Recurrent decay will not be covered under this warranty. If the tooth breaks and requires a crown, we will credit the cost of the filling towards the crown. **You must keep the prescribed regular exam and cleaning appointments or this warranty is null and void (minimum every 6 months).**

ROOT CANALS:

Root canal treatment is about 96% successful. They do occasionally fail or need to be retreated due to reinfection. Retreatment is not covered under this warranty. If you lose your tooth within **2 years** due to failure of the root canal, we will apply the cost of the root canal as a credit towards a replacement tooth. **You must keep the prescribed regular exam and cleaning appointments or this warranty is null and void.**

CROWNS, BRIDGES, INLAYS AND ONLAYS:

We will replace or repair them at a prorated fee for a 5-year period if they break with normal use. **Decay will not be covered under this warranty.** This does not include accidents that could break normal healthy teeth. Replacement fees will be prorated as follows: Up to 1 year, you pay 0%, from years 1 to 2- you pay 20% of regular the fee, from years 2 to 3 you pay 40%, from years 3 to 4 you pay 60%, from years 4 to 5 you pay 80%. After 5 years the regular fee will apply. **You must keep the prescribed regular exam and cleaning appointments or this warranty is null and void**.

NOTE: The primary key to long term success is good nutritional habits, proper home care: brushing, flossing and using prescribed products. The second key to success is regular professional cleanings, radiographs (x-rays) and examinations. This warranty does not apply if you have chosen an alternate treatment plan to the one that was recommended. This warranty also does not cover accidents that cause damage to the teeth or dental prosthesis.

Date: _____/_____/_____ Patient's Signature: ______________________________

Parent or Responsible Party: ______________________ Relationship to Patient: __________

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