

Patient Registration and Medical History

PLEASE PRINT

Date: _____

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

Driver License # _____

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 Prolapse
- 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: _____

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.

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

Please Note and initial items below:

- _____ I understand that Dr. de la Torre is not an “in-network” dentist with any dental insurance with the exception of Delta Dental Premier.
- _____ 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 24 hour notice is not given.

I have read this document and by signing below, I agree to abide by the above terms.

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 dental benefits, to include major medical/dental 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 for dental services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

In certain circumstances, insurance companies may send a check for dental services provided by Dr. de la Torre directly to the patient. In such cases, the patient agrees to endorse and send such a check to Dr. de la Torre's office. If the patient deposits such a check into a personal account, the patient agrees to send a personal check for the equivalent amount to Dr. de la Torre's office within 10 days of having deposited the check from the insurance company.

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 dental/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

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DELATORRE DENTISTRY

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

“ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW”, WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice or text mail, email or with a household family member.

[] Please check here if you do not want us to leave messages on your answering machine or with a household family member.

[] Please check here if you do not want us to leave a message on your mobile voice/text mail.

[] **Please check here if you authorize us to send your healthcare information by email. This may include estimates, dental insurance information or questions/answers about treatment, appointments or payments. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information _____
- You may request a copy of and you have the right to read our “*Notice of Patient Privacy Practices*” prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print): _____

Signature

Print name of person signing if other than patient

Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [] No [] RELATIONSHIP _____

FOR OFFICE USE ONLY

Patient refused to sign the form. Reason: _____ Date: _____

Oral Abnormality Screening Consent Form

Fact: One American dies every hour from oral cancer. We are very concerned about oral cancer and conduct screening examinations on every patient.

The incidence of Oral Cancer continues to rise in the USA. The American Cancer Society indicates that since 2010 there has been an alarming 11% increase in this deadly disease. **Alarmingly, 25 % of the new oral cancer cases are people that do not have any of the traditional life style risk factors, such as age, tobacco or alcohol use.**

Traditionally, our dentists and hygienists have done oral cancer screening with the naked eye, but recently a new technology, the **VELscope** has received FDA approval. The **VELscope** (for Visually Enhanced Lesion scope) **will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns.**

VELscope, similar to other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, safe, non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope hand piece and assists the hygienist or dentist find tissue abnormalities at an earlier stage. Before the exam, the room maybe darkened and much like "desert storm night vision technology" the clinician can see changes in tissue that may not be visible to the eye. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only 2 extra minutes to your appointment. The normal fee for this procedure is \$65, however, Dr. de la Torre feels so strongly that every patient has this examination at least once a year our charge for this enhanced examination is only \$35.00. The VELscope exam is recognized by the American Dental Association but may or may not be covered by dental insurances. As part of our standard of care and because we care about you, we strongly recommend that you choose this additional screening procedure.

Please sign the area below to accept the financial responsibility for this procedure or decline your oral cancer screening today.

Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients. Thank you for your kind consideration.

YES. I authorize the office to perform the VELscope examination and accept financial responsibility.

NO. I would prefer not to have the VELscope Oral Cancer exam at this time. I accept all risks.

Print Name: _____

Signature: _____ 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. X-rays must be taken at regular intervals. A minimum of 4 bitewings every 12 mts and a full mouth (FMX) every 5 years must be allowed. Refusing x-rays will void this warranty.**

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 **2 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 **18 months**. 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 if needed within 18 months. **You must keep the prescribed regular exam and cleaning appointments or this warranty is null and void (minimum every 6 months).**

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 or if broken by/at a specialist during treatment. 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 and 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: _____

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