MEDICAL HISTORY

Name _____ **Sex** _____ **Age** _____

Height _____ **Weight** _____ **Best Contact Phone #** _____

Current Medications: _____

_____

Allergies: *penicillin / codeine / iodine / other:* _____

Primary Care Physician (*name, city, phone*) _____

Specialist Physician (*name, city, phone*) _____

Major Illness, Hospitalization or Surgery: _____

History of Prior Sedation: (*general, IV, pills, laughing gas*) _____

Sedation Complications: (unusual reaction) _____

Motion Sickness: *Yes / No*

Do you require Antibiotic Pre-Medication prior to a Dental Appointment: *Yes / No*

Please indicate if you have a history of any of the following:

Yes	*No*		*Yes*	*No*	
☐	☐	Blood Thinners	☐	☐	Pneumonia
☐	☐	Heart Disease / Heart Attack	☐	☐	Thyroid Disorder
☐	☐	Heart Murmur	☐	☐	Glaucoma
☐	☐	Palpitations / Irregular Heartbeat	☐	☐	Prosthetic Joint
☐	☐	Mitral Valve Prolapse	☐	☐	Smoking (_____# / day)
☐	☐	Rheumatic Fever	☐	☐	Drink Alcohol (_____# / day)
☐	☐	Liver Problems / Hepatitis A / B / C	☐	☐	Psychiatric Treatment
☐	☐	Kidney Problems / Bladder	☐	☐	History of Tuberculosis
☐	☐	Cancer	☐	☐	HIV / AIDS
☐	☐	Radiation Therapy or Chemotherapy	☐	☐	Women - Are you Pregnant?
☐	☐	Convulsions	☐	☐	Physical Limitations _____
☐	☐	Stroke / TIA	☐	☐	Blood Transfusion
☐	☐	Swelling of the Legs / Edema	OTHER: _____		
☐	☐	Diabetes I or II	☐	☐	Anxiety in the Dental Office?
☐	☐	Bronchitis	☐	☐	Have you ever taken Bisphosphonates: Aredia, Zometa, Didronel, Boniva, Skelid, Fosamax, Actonel, Enbrel?
☐	☐	Emphysema			
☐	☐	Arthritis			
☐	☐	Asthma			

What is your primary dental concern? _____

Signature: _____ **Date:** _____

FOR OFFICE USE - to be completed by nurse:

Blood Pressure _____

Pulse _____

O2 Sat _____

Resp _____

Airway _____

Medical Clearance Yes / No _____

Procedure: _____

Duration: _____

Date of Surgery: _____

Time of Surgery: _____

Medications Starting Pre-Op: _____

Meds to Stop Pre-Op: _____

Juan Teodoro, DMD
PERIODONTICS & IMPLANTS

PATIENT REGISTRATION

First Name: _____ **Last Name:** _____ **Middle Initial:** _____
Preferred Name:_____
Referred by: _____ **Preferred Dentist:**_____

Patient Information:

Address:_____
City: _____ STATE:_____ ZIP CODE: _____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Birth Date:_____ Soc. Sec:_____ Drivers Lic:_____
Email:_____
Sex: ○Male ○ Female
Marital Status: ○Married ○Single ○Divorced ○Widowed ○Under 18 years old
Employment Status: ○Full Time ○Part Time ○Retired ○Student ○Other Occupation: _____

Does the patient have Dental Insurance? ○No ○Yes (If yes, please fill out information below)

Is the patient the policy holder? ○Yes ○No (If no, please fill out the Responsible Party Section)
Primary Dental Insurance Information
Subscribers Name: _____ Relationship to Subscriber: ○Self ○Spouse ○Child ○Other
Subscriber SSN or Subscriber ID:_____Subscriber Birth Date:_____
Insurance Company:_____Group #: _____
Insurance Company Phone Number:_____

Responsible Party (if someone other than the patient):
-Responsible Party is also a Policy Holder/Subscriber for Patient's Insurance

First Name:_____ Last Name:_____ Middle Initial:_____
Address:_____
City: _____ STATE:_____ ZIP CODE: _____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Birth Date:_____ Soc. Sec:_____ Sex: ○Male ○ Female
Marital Status: ○Married ○ Single ○ Divorced ○ Widowed Employment Status: ○ Full Time ○ Part Time ○ Retired ○ Other
Occupation: _____

EMERGENCY CONTACT INFORMATION:

First Name: _____ Last Name: _____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Relationship to Patient:_____

PHARMACY INFORMATION:

Preferred Pharmacy: _____Phone Number:_____
Location: _____

Financial Policy & Appointment Agreement

Bonita Periodontics & Implants

To avoid any misunderstanding regarding this policy, it is necessary for you to read and sign this financial policy before treatment.

1. **PAYMENT AT TIME OF SERVICE:**

INITIAL _____ It is our policy that payment is due at the time of service. We cannot send statements to other persons.

INITIAL _____ For payment: We accept CASH, PERSONAL CHECKS, MASTERCARD, VISA, DISCOVER AND AMERICAN EXPRESS. We also offer payment plans available with CareCredit Credit Card.

2. **FOR PATIENTS WITH IN-NETWORK DENTAL INSURANCE:**

INITIAL _____ We are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. However, this is an estimate of benefits. We are third party to insurance carriers. All fees are patients' responsibility; we will make a good forth effort to prepare your claims and receive payment. Not all of the services we provide are covered benefits. Benefits differ by dental plan. Fees for non-covered services along with deductibles and copayments are due at the time of service. Patients will be responsible for all outstanding fees after 45 days. To extend the benefit of accepting insurance payment directly to our office, we ask that you leave a credit card number on file with us. This card will be charged any remaining balances unpaid after 45 days*.

INITIAL _____ I understand that I am financially responsible for all charges incurred and that this office cannot guarantee coverage by my insurance. I understand that I am fully liable for all treatment rendered and insurance coverage verification does not guarantee payment as per your insurance company.

INITIAL _____ I agree to pay all late fees (5% of any balance that is not paid in 45 days of the treatment date)

If you do not wish to leave a card on file you will be required to pay for treatment in full at the time of service. Our office will file your insurance and assign any benefits directly to you. This means that your insurance will send any payment directly to you.

VISA, MASTER CARD, DISCOVER, AMERICAN EXPRESS

Card Number: _____

Expiration Date: _____CVV:_____

Signature: _____

**Any balance under $100.00 will not be notified prior to running a transaction*.

INITIAL _____ If a patient has any additional insurance companies (i.e. secondary dental insurance and/or medical insurance) it is their responsibility to file/submit to those insurance carriers. The office will not be of assistance to these additional companies.

INITIAL _____ If your primary dental insurance carrier and/or plan has changed, it is your responsibility to notify the office at least 48 hours prior to your appointment. Failure to notify the office will result in a fee for service appointment and no claims will be filed for that date of service.

INITIAL _____ I understand that I must present my dental insurance card to the office for them to obtain a copy.

3. **COLLECTIONS:**

INITIAL _____ Please note that any unpaid balance greater than 90 days will be subjected to referral to a collection department. If we must refer your account to a collection agency, you have agreed to pay all our incurred collection costs. Any bounced checks not reconciled will be sent to the State Attorney's Office.

4. **APPOINTMENT AGREEMENT:**

INITIAL _____ It is important to us that patients show up for their scheduled dental appointments. Missed or broken appointments result in a loss of valuable time, which could be utilized to serve other patients in need. If you are more than 15 minutes late for an appointment this will be counted as a "broken appointment". When you arrive 15 minutes late, it may not allow Dr. Teodoro & the staff enough time to give you the quality care you deserve, and it would be unfair to keep our other patients waiting because of another's tardiness.

INITIAL _____ We understand that situations arise and occasionally an appointment must be rescheduled. If you need to reschedule, please call our office as soon as you know that you will not be able to attend your scheduled appointment.

INITIAL _____ A non-refundable fee of $75 will be charged to patients missing periodontal maintenance appointments with our hygienist without 24-hour notice. After two missed appointments in a calendar year, pre-payment will be required for all appointments.

INITIAL _____ A deposit of 50% must be made in advance to schedule your surgical appointment.

INITIAL _____ A non-refundable fee of 50% surgical appointment will be charged to patient missing their surgery appointment without a 48-hour notice.

5. RED FLAG RULE

The Red Flag Rule was created by the Federal Trade Commission, along with other government agencies such as the National Credit Union Administration, to help prevent identity theft. The rule was passed in January 2008. In order to comply with this rule, our office will be requiring the following information in order to be treated in our facility.

INITIAL _____ All new patients will be required to present a valid photo identification card issued by a local, state or federal government agency, and we shall copy said identification to keep in your files.

a) In the case where the new patient is a minor, photo identification of the patient's responsible part will be obtained; and
b) In the case where a new patient does not have a valid photo ID, two forms of non-photo identification, one of which is issued by a state or federal agency, will be obtained as well as a water or utility bill or other form identifying the correct or current address.

If Patient Refuses to Present Identification:

a) In an emergent situation, we shall refer the patient to the nearest hospital for care;
b) In a non-emergent situation, we shall reschedule the appointment for a later date in which the patient will be required to bring the necessary identification.

I have read the Financial Policy & Appointment Agreement and I agree to this policy.

_____
Print Patient Name (if applicable print parent or guardian name as well)

_____ _____
Patient (Parent or Guardian Authorized Signature **Date**

NOTICE OF PRIVACY PRACTICES – HIPAA

Disclosure of Health Information

I authorize the professional office of my dentist to use and disclose health information for treatment, payment, communication with other healthcare providers and healthcare operations. You may give us written authorization to disclose health information to anyone for any purpose; in addition, any authorization may also be revoked in writing. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. In the event of an emergency we will disclose information based on our professional judgment. My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

-Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
-Any intraoral photos taken may be used for insurance claims, academic educational purposed or to share with your dentist.
-Obtain payment from third—party payers for my health care services.
-Conduct normal health care operations such as quality assessment and improvement activities.

It is completely your decision whether to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

I give my authorization for Dr. Teodoro and his staff to discuss my care and treatment with the following individual(s) other than my healthcare providers:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Trust Contact Information: _____

_____
Print Patient Name (if applicable print parent or guardian name as well)

_____ _____
Patient (Parent or Guardian Authorized) Signature **Date**