## Patient Information

Name:_________________________________________ DOB(MM/DD/YY): ___________Sex: M___ F___
Address: ______________________________________________________________________________
City: _______________________________ State:________________________ Zip Code:____________
Cell phone: _____________________________ Home phone: __________________________________
Email address: __________________________________ Referred by: _____________________________
Emergency Contact: ________________________ Phone Number: ______________________________
Primary Care Physician: _____________________ Phone Number: ______________________________

## Insurance Information

☐ No Insurance ☐ Insurance through work (see below)

**Primary Policy Holder**

Name: ____________________________________________ DOB (MM/DD/YY): ___________________
Insurance Company: ____________________________________ Telephone #: _____________________
SSN/ID#: ________________________ Employer: ____________________________________________

**Secondary Insurance**

Name: ____________________________________________ DOB (MM/DD/YY): ___________________
Insurance Company: ____________________________________ Telephone #: _____________________
SSN/ID#: ________________________ Employer: ____________________________________________

## Adult Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Date of last Physical: ______________________ Do you need to take antibiotics before dental visits? ☐ Yes ☐ No

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: ____________________________

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: ____________________________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: ____________________________

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: ____________________________

Are you taking any herbal or vitamin supplements? ☐ Yes ☐ No If yes, please explain: ____________________________

Have you ever taken Fosamax, Boniva, Actonel
or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes, please explain: ____________________________

Do you use controlled substances? ☐ Yes ☐ No Are you on a special diet? ☐ Yes ☐ No Do you use Tobacco? ☐ Yes ☐ No

**Women:** Are you:
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______________________________

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

| | | | |
|---|---|---|---|
| □ AIDS/ HIV Positive | □ Convulsions | □ Heart Murmur | □ Pain in Jaw Joints (TMD) |
| □ Alzheimer's disease | □ Cortisone Medicine | □ Heart Pacemaker | □ Parathyroid Disease |
| □ Anaphylaxis | □ Diabetes | □ Heart Trouble/Disease | □ Psychiatric Care |
| □ Anemia | □ Drug Addiction | □ Hemophilia | □ Radiation Treatments |
| □ Arthritis/Gout | □ Emphysema | □ Hepatitis A, B, or C | □ Recent Weight Loss |
| □ Artificial Heart Valve | □ Epilepsy or Seizures | □ Herpes | □ Renal Dialysis |
| □ Artificial Joint | □ Excessive Bleeding | □ High Blood Pressure | □ Rheumatic Fever |
| □ Asthma | □ Excessive Thirst | □ High Cholesterol | □ Shingles |
| □ Blood Disease | □ Fainting Spells/Dizziness | □ Hives or Rash | □ Sinus Trouble |
| □ Blood Transfusion | □ Frequent Cough | □ Hypoglycemia | □ Stroke |
| □ Breathing Problem | □ Frequent Diarrhea | □ Irregular Heartbeat | □ Swelling of Limbs |
| □ Bruise Easily | □ Frequent Headaches | □ Kidney Problems | □ Thyroid Disease |
| □ Cancer | □ Gastro Intestinal Disease | □ Leukemia | □ Tuberculosis |
| □ Chemotherapy | □ Genital Herpes | □ Liver Disease | □ Tumors or Growths |
| □ Chest Pains | □ Glaucoma | □ Lung Disease | □ Ulcers |
| □ Cold Sores/Fever Blisters | □ Hay Fever | □ Mitral Valve Prolapse | □ Venereal Disease |
| □ Congenital Heart Disorder | □ Heart Attack/Failure | □ Osteoporosis | □ Yellow Jaundice |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

Comments:

______________________________

______________________________

______________________________

______________________________

I, the undersigned verify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician being contacted if necessary to obtain information that is required for my dental care. I authorize the dentist to perform the diagnostic procedure that may be required to determine the necessary treatment and assume financial responsibility for dental services rendered.

Signature: ______________________________ Date: ________________________

**Office use only**

Doctor Signature: _________________________

## Dental History

1. - What is the primary reason for this appointment? ______________________________________________________
_____________________________________________________________________________________________

2.- When did you last see a Dentist? ___________________________ Reason? _____________________________

3.- When was you last hygiene visit (cleaning) ____________________________________________________________

4.- Are you experiencing any dental pain? If yes, how long has it been? ______________________________________
_____________________________________________________________________________________________

5.- Have you had an unfavorable dental/medical experience in the past? If yes, please explain: ________________
_____________________________________________________________________________________________

6.- Have you ever injured your teeth or mouth? If yes, please explain: _______________________________________
_____________________________________________________________________________________________

7.- Have you ever had orthodontic treatment (Braces)? ____________________________________________________

8.- Did you have your 3rd molars (wisdom teeth) removed? _________________________________________________

9.- Do you have any oral habits like teeth grinding? ________________________________________________________

10.- How often do you brush your teeth? _____times/day

11.- How often do you use floss? _____times/day

12.- How would you describe the current condition of your teeth? ____________________________________________

13.-What aspect of your smile would you like to correct? ___________________________________________________

14.- Do you have any cosmetic concerns about your smile? __________________________________________________

To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT ________________________________________________ Date _________________________

## ***Patient Privacy Consent Form***

Privacy of your personal information is an important part of our office. We are committed to collecting, using, and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this Office, Dr. Liliana Gomez-Infante and Dr. Gustavo Infante act as the privacy information officers. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information. Do not hesitate to discuss our policies with any member of our office staff.

At Glad Specialized Family Dentistry, we ensure that only necessary information is collected about you. We only share your information with your consent; storage, retention and destruction of you personal information complies with existing legislation, and privacy protection protocols, our privacy protocols comply with privacy legislation standards of our regulatory body and the law.

**We will collect, use, and disclose information about you for the following purposes:**

- To deliver safe and efficient patient care
- To ensure continuous high quality service
- To assess your health needs
- To advise you of treatment options
- To communicate with other treating health care providers, including specialists and general dentists, referring dentists, and/or peripheral dentists.
- To enable us to contact and maintain communication with you, to book and confirm appointments.
- To allow us to efficiently follow up on your treatment and ongoing care
- To facilitate the billing process
- To complete and submit dental claims on your behalf
- To comply with legal and regulatory requirements according to the provisions of the regulated health professions Act and also for other regulatory and monitoring purposes.
- To present individual cases for teaching and demonstrating purposes on an anonymous basis.

Our office will not under any conditions supply your insurer with you confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. By signing the consent section of this patient privacy consent below, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your information; we will seek your approval in advance. You may withdraw your consent for use and/or disclosure of your personal information and we will explain the ramifications of that decision and the process.

---

**Patient Privacy Consent**

I have reviewed the above information that explains how your office uses my personal information, and the steps your office is taking to protect my information. I know that your office has a privacy code, and I can ask to see the code at any time. I agree that Glad Specialized Family Dentistry can collect, use and disclose personal information about ______________________________ as set out about in the information about the office's privacy policies.

______________________________ ____________________
Signature Date (mm/dd/yy)

Signature of Witness: ________________________________

**NO SHOW / CANCELLATION POLICY**

In an effort to provide the highest quality care and service to our patients, we ask that you notify us 48 hours in advance to cancel and/or reschedule your reserved appointment.

We require confirmation for all appointments. As a courtesy to you we employ the use of a confirmation service to improve the efficiency of your ability to confirm you appointments by

- Email
- Text Message
- Phone Call

This system was implemented to limit the amount of last minute cancelations/no shows due to the high demand for dental care.

**Failure to cancel and/or reschedule an appointment within the appropriate time frame will result in a $25.00 charge.**

We value our patient/doctor relationships and will do everything we can to accommodate you. Your communication and compliance are not only very much appreciated but will help us to help you achieve a positive outcome.

Thank you in advance for your cooperation. Your cooperation enables us to serve the needs of all our patients.

By signing below, I acknowledge I have read and understand the No Show/Cancelation Policy

______________________________________________________________________

Patient Name DOB

______________________________________________________________________

Patient/Parent Signature Date

We are privileged you have chosen us as your dental provider. We are committed to providing you and your family with quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to the commencement of dental treatment. If you have any questions, please feel free to ask.

## FINANCIAL POLICY

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, checks, and most major credit cards. There will be a $35.00 fee on all returned checks. Also, we reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.

**Regarding Insurance**

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you.

Before treatment, we will verify your coverage and calculate your deductible and co-payments as accurately as possible. Please understand that all treatment plans given are only an estimate based on the information your insurance company provides. All deductibles and co-payments are due the day treatment is rendered.

Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim. **REGARDLESS OF WHAT YOUR INSURANC E COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL.** Once a payment is received on your claim, we will send you a bill for any remaining balance on your account.

At your discretion, any unpaid balance after 90 days will be sent to collections at which time the patient is responsible for any fees associated with the collection of the balance. I understand that should my account become delinquent, I will be legally responsible for all costs involved with the collection of this account including collection fees and attorney fees.

*I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.*

________________________________________ ___________________________

Signature of Patient Date