



CARLOS A. PIEDRA
DENTISTRY

5717 SW 75TH STREET
GAINESVILLE, FL 32608
P 352.378.1700 • F 352.260.0970

PATIENT INFORMATION

Today's Date ____/____/____

Patient's Name _____
First MI Last

Please let us know if you have a nickname or preferred name by which you wish to be called _____

Sex M F Date of Birth ____/____/____ Single Married Widowed Divorced

Home Address _____
Street City State Zip

Phone # (____) _____ (____) _____ (____) _____
Home # Work # Mobile #

Social Security # _____ E-mail Address _____

Are you a full time student? Yes No If yes, School Name _____

Employer _____
Name Address City State Zip

Has any member of your family been treated in our office? Yes No If so, who? _____

How did you hear about our office? _____

Contact in case of emergency _____ (____) _____
Name Relationship Phone #

Spouse or Parent, if minor _____ (____) _____
Name Address Phone #

Person Responsible for Account _____
Name Relationship SS#

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____
First MI Last

Subscriber's ID # _____ Subscriber's Date of Birth ____/____/____

Subscriber's Employer _____
Name Address City State Zip

We will need to copy your insurance card or please provide us with the following information so we may verify coverage:

Insurance Company _____
Name Address City State Zip

Insurance Company Phone # (____) _____ Group # _____ Local Union #, if any _____

I authorize this office to perform diagnostic procedures (examination, x-rays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs.

Patient, Parent or Guardian Signature _____ Date ____/____/____

I understand this office may photograph my face and mouth for purpose of documentation in my patient chart. _____ (Initial)

Patient, Parent or Guardian Signature _____ Date ____/____/____



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PATIENT MEDICAL HISTORY

Today's Date ____/____/____

Patient's Name _____ Date of Birth ____/____/____

- 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: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? 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 <input type="radio"/> Yes <input type="radio"/> No	Convulsions <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Aneurysm <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Bleeding Disorder <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Breathing Problem <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Major Surgery <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

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

Do you need to be premedicated before dental treatment? Yes No

Have you ever had a reaction or experienced complications to any dental treatment in the past? Yes No

Do you wish to speak privately to the dentist about any problems? Yes No

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or my child) ever have any change in health status or medications being taken or if I (or my child) have any abnormal medical test results, I will inform the dentist at the next appointment without fail.

Patient, Parent or Guardian Signature _____ Date _____



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REGARDING PATIENT PRIVACY

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____



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Welcome to our office!

We believe in optimum communication with our patients; therefore, we ask that you please read the following information and ask any and all questions so we may help you fully understand our financial and appointment policies.

FOR OUR PATIENTS FORTUNATE ENOUGH TO HAVE DENTAL BENEFITS:

Your dental benefits help offset the investment of getting quality dental care performed on you and your family and it is our pleasure to assist you in maximizing your insurance benefits by completing your claim forms. Please be aware that your coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office. Please understand that any assistance concerning what or how much coverage you have, whether by phone or mail, is for reference only and should not be your only basis for proceeding with treatment. We do not base our treatment recommendations on what the insurance company will cover but rather what the best treatment is for you. We will assist you in any way that we can (including electronic claims submission). In addition, because of the inconsistencies in secondary insurance benefits, we do not consider the secondary benefits when figuring your portion of the charges. We will file your secondary claims for you and the payments from your secondary can be assigned to you. We collect estimated portions calculated by our computer system up front; if there is any remaining balance after receiving this portion plus any portion your primary carrier pays, it will be due upon receipt of our statement. If for any reason, we have not received your insurance carrier's payment 90 days after the claim, the remaining balance will be due and payable by you and subject to interest charges (18% APR). Thanks for your understanding.

FINANCIAL AGREEMENT (FOR ALL PATIENTS):

Upon acceptance of treatment in this office the patient/guardian assumes financial responsibility for payment of fees. Treatment is to be paid in full when services are rendered unless other arrangements have been discussed and finalized. This may be in the form of Cash, Check, Visa, MasterCard, Discover or other outside financing. Any balances over 90 days old will be assessed a finance charge of 18% APR. In the event it should become necessary to place your account in the hands of an attorney or collection agency, you will be responsible to pay all costs of collection, including attorney's fees.

REGARDING APPOINTMENTS:

Our time is valuable and so is yours. Our commitment to you is:

- We always try to make appointments that are convenient for you.
- We will not ask you to make a schedule change unless it is an extreme emergency.
- We will always be conscious of your personal time and will try to start your dental appointments on time and complete your treatment as efficiently as possible.

Please understand that **we reserve chair time just for you** when you make an appointment with us. In an effort to continually provide quality service, we ask that you keep your reserved appointment as it is scheduled. **Please give our office 48 hours (or more) notice if you need to change your appointment, or a \$50 fee will be assessed to your account.**

Please keep us informed of any changes to your health information as well as your address, phone, email or insurance information so that we may serve you in the best possible manner.

I have read and understand the above financial policies. I authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

X _____
(Patient or Parent or Guardian signature)

(Date)

X _____
(Print patient's name)