DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

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Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Parent, Guardian or Personal Representative

_____ Date

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone (____) _____

ALLERGIES

☐ Aspirin	☐ Sulfa
☐ Barbiturates (Sleeping pills)	☐ Latex _____
☐ Codeine	☐ Other _____
☐ Local Anesthetic	_____
☐ Penicillin	

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

Dental Insurance Policy

Dental insurance plans are often misunderstood by patients who generally have expectations for coverage that are far greater than their policies will actually provide. The insurance providers only give the dentist a minimal amount of information about the patient's policy/coverage benefits. The dentist must use this very basic information to estimate the coverage amounts and dental benefits for any treatment procedures.

The insurance companies always state that the benefits/coverage amounts are never guaranteed, regardless of any information provided over the phone or FAX machine. Therefore, the dentist can only provide you with an estimate for your coverage based on past history, experience and the limited information provided by the insurance company. For expensive treatments or questionable treatments a pre-treatment estimate (permission) must be sent in to the insurance company and an answer will arrive in about 4 weeks. Even some routine procedures can require a pre-treatment to be approved for payment.

The patient must be aware when he/she undergoes dental treatment that financial responsibility remains with the patient until the claim is fully paid by the insurance company. The insurance plan is a contract between the patient and the insurance company. The dentist has only agreed to accept and abide by the insurance guidelines. The dentist is not an agent for the insured or the insurer.

I have read the above statement and understand that any amount not paid by my insurance company is my responsibility and I agree to pay the amount in full in a timely manner upon notification. I also understand that if my unpaid bill goes into collection, that I am responsible for all collection costs including a 35% collection fee.

Signature_____

Date_____

DRS. OLEY & QUILEZ DDS PLC

PATIENT FINANCIAL AGREEMENT

Welcome and thank you for choosing us to be your dental provider. It is important to us that you are perfectly comfortable and clear regarding fees, services or any other questions you may have.

Payment

We accept VISA, MASTERCARD, AMEX, CARE CREDIT AND DISCOVER.

Regarding Insurance

It's wonderful that you have dental insurance to help cover part of the cost of your dental care. We want to cooperate with you to make the most effective use of your insurance benefits. As a courtesy to you, we accept assignment of insurance benefits. ***However, we can only estimate what those benefits will be. We do require your estimated portion of the bill to be paid at the time of service.*** Our practice is committed to providing the best treatment for our patients and we charge what is typical for our area.

We are in-network provider and you are responsible for any remaining fees after the insurance company has made payment. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Generally, the more you and your employer pay for the insurance, the more dental services the insurance will cover. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under your insurance plan. It is possible your insurance company will not pay 100% of their share of the fee.

All of our patients, insured or not, receive the highest quality of dental care and are charged the same fee. Every effort is being made to keep the cost of dental care down; therefore your prompt payment of dental services will be appreciated.

We hope this clarifies our office policy regarding payment arrangements. If you have any questions, please feel free to ask our financial coordinator.

Thank you for your support and cooperation.

_____ _____

Signature Date

MISSED APPOINTMENT POLICY

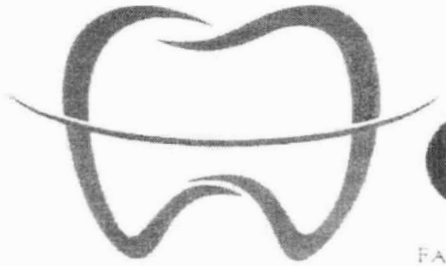
We want to thank you for choosing us as your dental health provider. In order to provide you with the best optimal dental care; we request that you follow our guidelines regarding broken and/or cancelled appointments.

Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses—you, the doctor and the other patients that would like to have utilized your appointment time.

Please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your dental office choice.

_____ _____

Signature Date



OLEY & QUILEZ

FAMILY DENTISTRY AND ORTHODONTICS

Fluoride Consent Form

Fluoride Application is an important part of your oral health. Fluoride helps prevet new decay from developing; it also helps protect existing dental work so that fillings are replaced less frequently, decreases sensitivity, makes teeth last longer and ***saves you money!*** Fluoride is most effective when applied after the dental cleaning and all the plaque and build up have been removed from the tooth's surface. It is our office protocol to apply fluoride varnish at each routine care appointment for you to receive maximum benefit. Most insurances cover fluoride for children. Please check with the front desk to make sure it's covered for your child because some insurances have age limits. If you're an adult and interested in getting fluoride treatment the cost will be ***$36*** out of pocket and the same fee applies if fluoride is not covered for your child.

[ ] Yes, I give permission for fluoride treatment

[ ] No, I do not give permission for fluoride treatment

Print Name: _____

Signature: _____

Date: _____

DRS. OLEY & QUILEZ DDS PLC

Written Acknowledgement Form

Our notice of Privacy Practices provides information about how we may use and disclose PHI about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _____(print name) have received a copy of Drs. Oley & Quilez Notice of Privacy Practices.

I understand that I may ask questions to Drs. Oley & Quilez if I do not understand any information contained in the Notice of Privacy Practices.

_____

Patient Signature

Please list any members of your family that you would like to include:

_____

_____

If you are not the patient but are the authorized representative for this patient please fill this part out

Signature of Authorized Rep for patient: _____

Relationship to patient: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning you health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at anytime, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations.
For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of you incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in a disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit.

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence