



NEW PATIENT FORMS

Patient Name: _____ Today's Date: _____

DOB: _____ Age: _____ Gender: _____

Social security: _____ Marital: (please circle one) Single Married Widowed

Address: _____ City: _____

State: _____ Zip: _____

Primary Phone: Home Cell _____

Email: _____ Primary Language: English Spanish Other: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

What is the reason for your visit / Chief Complaints?

How did you hear about us?

Primary Insurance Information

Insurance Company: _____

Employer: _____ Policy Holder's Name: _____

Policy Holder DOB: _____ Policy Number: _____

Group Number: _____ Patient Relationship to subscriber: _____

Secondary Insurance Information

Insurance Company: _____

Employer: _____ Policy Holder's Name: _____

Policy Holder DOB: _____ Policy Number: _____

Group Number: _____ Patient Relationship to subscriber: _____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company and assign directly to Dr. Quilez for all insurance benefits, if any, 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 dental facility may use my healthcare 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 benefits payable to related services. This consent will stay in effect as long as I am a patient with the above-named medical facility.

Signature of Patient, Parent, Guardian, or Personal Representative Name of Patient, Parent, Guardian, or Personal Representative

Print: _____

Sign: _____

Date: _____

Relationship to Patient: _____

Preferred Pharmacy Information:

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Street Address: _____

Dental History and Oral Health

Date of last dental visit: _____ Date of last dental X-ray: _____

Have you ever been treated for periodontal disease? Yes No

Have you ever had Novocain / other local anesthetic? Yes No

On a scale of 1 (not happy) to 10 (very happy), how happy are you with your smile? _____

Please check any dental conditions that apply to you:

Pain in Jaw (TMJ) Teeth Grinding / Clenching Use Tobacco Products Swollen / Bleeding Gums
 Mouth Sores Broken / Loose Teeth Sensitive Teeth Difficulty Chewing / Swallowing Crooked
/ Spaced Teeth Tooth Color / Appearance

Are you in pain? Yes No

Do you experience any fears or anxieties related to dental treatment?

Yes No If Yes, please explain:

Do you need to be pre-medicated before dental treatment? Yes No

Medical History

Primary Care Provider:

Name : _____ Phone: _____

Date of last physical: _____ Are you taking birth control? Yes No Not Applicable

Are you currently pregnant or nursing? Yes No Not Applicable

Estimated due date, if applicable: _____

Please list any prior hospitalizations or surgeries, including dates:

Is the patient currently using alcohol or drugs (including tobacco)? Yes No

Do you require antibiotics prior to dental procedures? Yes No

Are you currently taking or have you taken any steroid / cortisone therapy in the last 2 years?

Yes No

Are you allergic or have you ever had an adverse reaction to any of the following?

None Amoxicillin Aspirin Codeine Epinephrine Latex Ibuprofen Metals Penicillin
 Sulfa Tetracycline Erythromycin Z-pack

Please list any current prescribed medications or supplements you are taking, or have used over a long period of time (e.g. prescription, dosage, dates)

<i>Prescription/Supplement name</i>	<i>Dosage/Frequency</i>

Conditions (Please circle all that apply) NONE

AIDS/HIV positive: YES NO

Hay fever/Allergy/Hives: YES NO

Swollen Ankles Stroke: YES NO

Artificial Joints (hip, knee, etc.): YES NO

Heart Murmur: YES NO

Thyroid Problems: YES NO

Artificial Heart Valve/Pacemaker: YES NO

Heart Surgery/Disease/Attack: YES NO

Tuberculosis: YES NO

Arthritis/Rheumatism: YES / NO

Hemophilia: YES NO

Tumors: YES NO

Asthma: YES NO

High/Low Blood Pressure: YES / NO

Ulcers: YES NO

Blood transfusion: YES NO

Glaucoma: YES NO

Stroke: YES NO

Cancer: YES NO

Kidney Trouble: YES NO

Venereal disease: YES NO

Chemotherapy: YES NO

Mitral Valve Prolapse: YES NO

Epilepsy/seizures: YES NO

Chest Pain: YES NO

Pace Maker: YES NO

Sinus issues: YES NO

Chronic cough: YES NO

Psychiatric care: YES NO

STD/STI: YES NO

Cold Sores/fever blisters: YES NO

Rheumatic Fever: YES NO

Diabetes: YES NO

Congenital Heart Disease: YES NO

Patient Signature: _____ Date: _____ Doctor's Signature: _____ Date: _____

Informed Consent to Treatment Drugs and Medication

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). (Initial: _____)

Changes in Treatment Plan: I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary once they've been discovered and discussed. (Initial: _____)

X-Rays: I understand x-rays are necessary for proper diagnosis and treatment. (Initial: _____)

Fillings: I understand that care must be exercised in chewing on fillings, especially during the first 24 hours, to avoid breakage. I understand that a more expensive filling may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common after effect of a newly placed filling. (Initial: _____)

Local Anesthetic: Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection. Risks include but are not limited to.' It is normal for the numbness to take time to wear off after treatment, usually two to three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur. Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during dental treatment. (Initial: _____)

General Consent to Treatment

I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction. I consent to the proposed treatment. (Initial: _____)

1. I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan. 2. I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee. 3. In general

terms, the dental procedure(s) can include is not limited to: a. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride b. Application of resin “sealants” to the grooves of the teeth c. Treatment of diseased or injured teeth with dental restorations (fillings) d. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or infections 4. I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service. 5. I certify that if I and/or my dependents have insurance coverage, I assign directly to the dentist all insurance benefits 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. 6. I have answered all of the questions about me or my dependent’s medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment. 7. I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner, and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Relationship to patient: _____

Print name: _____

Signature: _____

Date: _____

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your dental provider. In order to provide you with the best optimal care; we request that you follow our guidelines regarding broken/missed appointments. Please remember we have reserved appointment times especially for you. Therefore, we request at least 24 hour 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 preferred dental office.

There is a late cancellation Fee within the 24-hourmark. Fees Subject to change depending on appointment.

Signature: _____

Date: _____

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU 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. The law also requires us to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. The 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 options.

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.

HEALTHCARE 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 healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another healthcare 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 those 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 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 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 or 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 voicemails, 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 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.

Acknowledgement of Privacy Practices

I have received the "Notice of Privacy Practices" and have been provided an opportunity to review it.

Print name: _____ Signature: _____ Date: _____

Parent/Guardian Name if Patient is a Minor:

Print name: _____ Signature: _____ Date: _____