Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Latex Allergy
☐ Local Anesthesia Allergy
OTHER:
☐ _____
_____

- List **ALL** medications you are currently taking: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____

Name of Physician: _____ Phone: _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) and ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with **Dr. Q DENTISTRY, "**Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

CONCENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD y CONFIRMACIÓN DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

Confirmo que se me ha proveido con la "Nota De Practicas De Privacidad" de **Dr. Q DENTISTRY,** y doy mi consentimiento para usar y compartir Informacion Personal De Salud como lo permitad y/o requiera la ley.

Patient's Name: X _____

Nombre del Paciente: (please print) (nombre en letra de molde por favor)

Patient's Signature: X _____ **Date:** _____

Firma Del Paciente: (Patient or legal representative*)(Paciente o Representante Legal*) **Fecha:**

*May be requested to show proof of representative status *Puede pedirse prueba de la representación

E-Mail/Text Consent Form

PURPOSE: This form is used to obtain your consent to communicate with you by email/text regarding your Protected Health Information.

Dr. Q DENTISTRY offers patients the opportunity to communicate by e-mail/text. Transmitting patient information by e-mail/text has a number of risks that patients should consider before granting consent to use e-mail/text for these purposes. **Dr. Q DENTISTRY** will use reasonable means to protect the security and confidentiality of e-mail/text information sent and received. However, **we** cannot guarantee the security and confidentiality of email/text communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of e-mail/text between **Dr.Q DENTISTRY** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

PROPÓSITO: Esta forma es usada como consentimiento de usted para comunicarnos vía e-mail/texto en referencia a su Información de Salud Protegida .

Dr. Q DENTISTRY ofrece a sus pacientes la oportunidad de comunicación vía e-mail/texto. Trasmitir información vía e-mail/texto tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos.

Dr. Q DENTISTRY usara formas razonables de proteger confidencial y seguro la información mandada a usted vía e-mail/texto. De todas formas, **Dr. Q DENTISTRY** no podrá garantizarle proteger confidencial y seguro la comunicación vía e-mail/texto y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía e-mail/texto entre **Dr. Q DENTISTRY** y yo y consentimiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

Patient's Acknowledgment and Agreement /Paciente Recibió y Acordó

Yo estoy de acuerdo y consiento que **Dr. Q DENTISTRY** se pueda comunicar en referencia a mi Información de Salud Protegida vía e-mail/texto.

I agree and consent that **Dr. Q DENTISTRY** may communicate with me regarding my protected health information by e-mail/text.

My Consented E-Mail Address is: _____

(Mi direccion de E-Mail consentida es)

Text to (mandar texto por telefono a): _____

Signature of Patient or Legal Representative X_____ **Date Signed:** _____

Patient Name: _____ Date: _____

CONSENT FOR SERVICES

I authorize the Doctor to take X-rays, study models, photography, or any other diagnostic aids deemed appropriate by the Doctor to make thorough diagnosis. I further authorize and consent that the doctor may choose and employ such assistance as he/she deems fit while making a diagnosis.

Initials _____

TREATMENT PLAN

After your initial examination we will discuss your oral health and recommended treatment plan with you. We will offer you treatment options where possible and plan treatment to address your most urgent needs first. In some cases, it is necessary to schedule urgent procedures prior to routine cleanings; otherwise, your routine cleaning will be scheduled at the next available appointment.

It is your sole responsibility to maintain your oral health. We will assist you in any way possible to facilitate your treatment.

Initials _____

REGARDING MINOR PATIENTS

Dr. Q Dentistry sees patients over the age of seven (7) years. An adult, parent or guardian must accompany all minor patients (under 18 years of age) and must remain on premises, outside the operatory, throughout the appointment. The parent or guardian accompanying the minor patient is legally responsible for any payments due at that appointment. Nitrous oxide, also known as "laughing gas", is mandatory for minor patients when performing any dental treatment with Dr Quintana, and will incur a charge of $70. Nitrous Oxide is optional for routine cleaning appointments.

Initials _____

REGARDING PATIENTS WITH CHILDREN

Dr. Q Dentistry cannot provide child care during appointments and, as provided by state regulations, children cannot accompany an adult into the operatory. Please make arrangements for your children's care accordingly.

Initials _____

FINANCIAL POLICY

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Payment for services is due before treatment is rendered. We accept cash, personal checks, Visa, MasterCard, Discover, and American Express. You may also qualify for interest-free loans available through a third party lender upon credit approval. See www.carecredit.com for more information on these loans.

A 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, you promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt.

I understand there is a **$25 FEE FOR ANY MISSED OR BROKEN APPOINTMENTS WITH DR. QUINTANA AND A $50 FEE FOR ANY MISSED OR BROKEN APPOINTMENTS WITH ANY OF OUR SPECIALISTS WITHOUT ONE BUSINESS DAY PRIOR NOTICE.**

Patient Name _____ Date: _____

All medical/dental records and x-rays are the property of this office. Any costs to transfer to another practitioner will incur a duplication fee of $2/page. If you would like to have the information sent electronically via email, there will not be a charge.

In the event of a returned check (NSF item) an additional amount of $30 (NSF fee) will be charged. Payment of the amount of the NSF item plus $30 NSF fee MUST be paid within 24 hours by cash, cashier's check, or money order.

Initials _____

YOUR INSURANCE

Dr. Q Dentistry has arranged to accept many insurances and dental health plans (assignment of benefits). We must emphasize that our relationship is with you, not your insurance company.

Claims are filed for plans classified as "indemnity", "fileable" , or "PPO". Those plans require you to pay the co-payment, deductibles and/or coinsurance at the time of service. We will file claims to all insurances for which we have an agreement with.

If your insurance cannot be verified prior to your appointment, you will be responsible for all charges of the appointment. Utmost effort will be made to notify you of any such circumstances. Patients will be given a receipt for reimbursement from their provider in circumstances where insurances cannot be verified.

If we do not have an agreement with your insurance carrier, we will provide you with a receipt with all the necessary information for you to file a claim. Your insurance company should send the benefit payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.

In the event your dental insurance or plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. If you disagree with the insurer's determination, you must contact your insurance company to resolve the dispute.

Benefits from your insurance are NOT a guarantee of payment.

You have the option to request a pre-authorization from your insurance company before services are rendered. The pre-authorization request can take anywhere from 2-4weeks, depending on your insurance. It is the patients responsibility to contact Dr. Q Dentistry once the pre-authorization has been received regarding any questions, or to make your next scheduled appointments.

Initials _____

ALTERNATE BENEFIT AND OTHER CLAUSES

Your insurance may contain clauses that affect the amounts paid by your insurance. Dr. Q Dentistry will notify you of such clauses whenever possible; however it is your responsibility, not Dr. Q Dentistry's, to be aware of these clauses for your particular insurance. For example, an "Alternate Benefit Clause" states that your insurance will only pay the cost for an amalgam or "silver" filling, not a composite or "tooth colored" filling. Dr. Quintana does not do silver fillings. Your responsibility for charges in this case would be the difference in cost between silver and tooth colored fillings, plus your co-pay according to your insurance plan.

Initials _____

Please sign below as acknowledgement and acceptance of these policies.

Printed Name of Patient/Guardian	Signature of Patient/Guardian	Date

Printed Name of Witness	Signature of Witness	Date