DosSantos Dental

Welcome

Please fill out this form completely, it is important for your care.

About You

Today's Date: _____ ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Name: _____ ☐ M ☐ F Birthdate: ____/____/____ Age: _____ SS#: _____
Last First MI

Home Address: _____
CITY STATE ZIP

Home #: (_____) _____ Cell #: (_____) _____ Work #: (_____) _____ DL#: _____

E-mail Address: _____ When are the best times to reach you? _____

Whom may we thank for referring you? _____ Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
CITY STATE ZIP

In the event of an emergency, whom should we contact?

His/Her Name: _____ Relation: _____ Home or Cell #: (_____) _____

Spouse Information

His/Her Name: _____ Birthdate: ____/____/____
Last First MI

Employer: _____ Cell #: (_____) _____

Person responsible for account, if other than yourself

His/Her Name: _____ Relation: _____ SS #: _____

Employer: _____ Cell #: (_____) _____ DL#: _____

Home #: (_____) _____ Billing Address: _____
CITY STATE ZIP

Dental Insurance Information

Insured's Name: _____ Relation: _____ Birthdate: ____/____/____ ID#: _____

Insured's Employer: _____ Employer's Address: _____
CITY STATE ZIP

Insurance Co. Name: _____ Ins. Co. Ph #: (_____) _____ Group # (Plan, Local, or Policy): _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Insured's Name: _____ Relation: _____ Birthdate: ____/____/____ ID#: _____

Insured's Employer: _____ Employer's Address: _____
CITY STATE ZIP

Insurance Co. Name: _____ Ins. Co. Ph #: (_____) _____ Group # (Plan, Local, or Policy): _____

Preferred Pharmacy Information

Pharmacy Name: _____ Phone #: (_____) _____

Pharmacy Address: _____
CITY STATE ZIP

Patient Dental History

What is the reason for your dental visit today? _____

Name of Previous Dentist and Location: _____

Date of Last Exam: _____ **Date of Last Dental X-Rays:** _____

Are you currently experiencing pain or discomfort?	☐ Yes	☐ No	**If yes, where?** _____
Are your teeth sensitive to hot or cold foods/liquids?	☐ Yes	☐ No	
Are your teeth sensitive to sweet or sour foods/liquids?	☐ Yes	☐ No	
Do you have any sores, ulcers or lumps in or near your mouth?	☐ Yes	☐ No	
Do you require antibiotics before dental treatment?	☐ Yes	☐ No	**If yes, for what condition?** _____
Do you ever experience dry mouth?	☐ Yes	☐ No	**If yes, when?** _____
Have you had any problems with previous dental treatment?	☐ Yes	☐ No	**If yes, what was the problem?** _____
Have you had any head, neck, or jaw injuries?	☐ Yes	☐ No	
Have you ever experienced any of the following problems in your jaw?			
Clicking	☐ Yes	☐ No	
Pain	☐ Yes	☐ No	
Difficulty in opening or closing	☐ Yes	☐ No	
Difficulty in chewing	☐ Yes	☐ No	
Do you have frequent headaches?	☐ Yes	☐ No	
Do you clench or grind your teeth?	☐ Yes	☐ No	
Have you had any orthodontic treatment?	☐ Yes	☐ No	
Do your gums bleed when brushing or flossing?	☐ Yes	☐ No	
Have you ever been told you have periodontal disease?	☐ Yes	☐ No	
Do you have any mobility in your teeth?	☐ Yes	☐ No	
Have you ever received oral hygiene instructions?	☐ Yes	☐ No	
Do you brush your teeth daily?	☐ Yes	☐ No	
Do you floss your teeth daily?	☐ Yes	☐ No	
Type of bristles on toothbrush:	☐ Hard	☐ Medium	☐ Soft
Do you use anything in addition to a toothbrush and floss?	☐ Yes	☐ No	**If yes, what?** _____
Do you wear dentures or partials?	☐ Yes	☐ No	**If yes, date of placement?** _____
Would you like whiter teeth?	☐ Yes	☐ No	
Are you happy with the way your smile looks?	☐ Yes	☐ No	

If not, what would you change? _____

To the best of my knowledge, the questions on this form 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, PARENT, OR GUARDIAN _____ **DATE** _____

Doctor's Comments: _____

_____

_____

_____

_____

Patient Medical Health History

Are you now under the care of a physician? ☐ Y ☐ N

Physician: _____ **Office Phone #:** (_____) _____ **Date of Last Exam:** _____

Are you in good health? ☐ Y ☐ N

Are you currently undergoing any medical treatments? ☐ Y ☐ N **If YES, please explain:** _____

_____

Are you currently taking any medications, pills, or drugs? ☐ Y ☐ N **If YES, please list each medication & reason for taking:**

_____

_____

_____

_____

Are you taking any BLOOD THINNERS (such as Coumadin, Warfarin, Xarelto, Pradaxa, Plavix, Heparin, Aspirin)? ☐ Y ☐ N

Do you take or have you ever taken any BIPHOSPHONATES or any medication to treat OSTEOPOROSIS or Paget's Disease? ☐ Y ☐ N
Some commonly prescribed drugs include: Alendronate (Fosamax), Risedronate (Actonel), Ibandronate (Boniva), Zolendronate (Reclast), Denosumab (Prolia)

Do you take or are you scheduled to take any IV MEDICATION? ☐ Y ☐ N
Possible treatment for bone pain, hypercalcemia, skeletal complications from Paget's disease, multiple myeloma or metastatic cancer

Do you take or have you ever taken Phen-Fen or Redux? ☐ Y ☐ N

Has a physician or dentist recommended that you take antibiotics before having dental work done? ☐ Y ☐ N

If YES, for what condition? :_____

Have you ever been hospitalized or had a major operation? ☐ Y ☐ N **If YES, please explain:** _____

_____

Have you had an orthopedic joint replacement? ☐ Y ☐ N **If YES, please explain:** _____

_____

Have you ever had a serious head or neck injury? ☐ Y ☐ N **If YES, please explain:** _____

_____

Do you use any tobacco or marijuana products (vaping, smoking, snuff, bidis, etc) ? ☐ Y ☐ N **If YES, please explain:** _____

Do you drink alcoholic beverages? ☐ Y ☐ N **If YES, how many drinks per week:** _____

Do you use any controlled substances (drugs)? ☐ Y ☐ N **If YES, please explain:** _____

WOMEN: Are you pregnant/trying to get pregnant? ☐ Y ☐ N
If pregnant, Week #:_____ **Taking oral contraceptives?** ☐ Y ☐ N **Nursing?** ☐ Y ☐ N

Are you ALLERGIC to any of the following?

☐ **NO ALLERGIES**
☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Local Anesthetics** ☐ **Acrylic** ☐ **Metals** ☐ **Latex** ☐ **Sulfa drugs**
☐ **Other :** _____

If yes, please explain: _____

Do you have, or have you had, any of the following? Please individually select Y or N

ADD / ADHD	☐Y ☐N	Chronic Pain	☐Y ☐N	Hemophilia	☐Y ☐N	Psychiatric Care	☐Y ☐N
AIDS/HIV Positive	☐Y ☐N	Congenital Heart Disorder	☐Y ☐N	Hepatitis A	☐Y ☐N	Radiation Treatment	☐Y ☐N
Alzheimer's Disease	☐Y ☐N	Congestive Heart Failure	☐Y ☐N	Hepatitis B or C	☐Y ☐N	Recent Weight Loss	☐Y ☐N
Anemia	☐Y ☐N	Cortisone Medication	☐Y ☐N	Herpes	☐Y ☐N	Recurrent Infection	☐Y ☐N
Angina	☐Y ☐N	Damaged Heart Valves	☐Y ☐N	High Blood Pressure	☐Y ☐N	Renal Dialysis	☐Y ☐N
Anxiety	☐Y ☐N	Diabetes	☐Y ☐N	High Cholesterol	☐Y ☐N	Rheumatic Fever	☐Y ☐N
Arteriosclerosis	☐Y ☐N	Drug Addiction	☐Y ☐N	Hives or Rash	☐Y ☐N	Rheumatism	☐Y ☐N
Arthritis/Gout	☐Y ☐N	Emphysema	☐Y ☐N	Hypoglycemia	☐Y ☐N	SexuallyTransmittedDisease	☐Y ☐N
Artificial Heart Valve	☐Y ☐N	Epilepsy or Seizures	☐Y ☐N	Irregular Heartbeat	☐Y ☐N	Shingles	☐Y ☐N
Asthma	☐Y ☐N	Fainting Spells/Dizziness	☐Y ☐N	Kidney Problems	☐Y ☐N	Sickle Cell Disease	☐Y ☐N
Autoimmune Disease	☐Y ☐N	Fibromyalgia	☐Y ☐N	Leukemia	☐Y ☐N	Sinus Trouble	☐Y ☐N
Blood Disease	☐Y ☐N	Frequent Cough	☐Y ☐N	Low Blood Pressure	☐Y ☐N	Sleep Disorder	☐Y ☐N
Blood Transfusion	☐Y ☐N	Frequent Headaches	☐Y ☐N	Lung Disease	☐Y ☐N	Spina Bifida	☐Y ☐N
Breathing Problems	☐Y ☐N	G.E. Reflux / Heartburn	☐Y ☐N	Lupus	☐Y ☐N	Stomach/Intestinal Disease	☐Y ☐N
Bronchitis	☐Y ☐N	Glaucoma	☐Y ☐N	Mental Health Disorders	☐Y ☐N	Stroke	☐Y ☐N
Bruise Easily	☐Y ☐N	Hay Fever	☐Y ☐N	Mitral Valve Prolapse	☐Y ☐N	Thyroid Problems	☐Y ☐N
Cancer	☐Y ☐N	Heart Attack/Failure	☐Y ☐N	Neurological Disorders	☐Y ☐N	Tonsilitis	☐Y ☐N
Cardiovascular Disease	☐Y ☐N	Heart Murmur	☐Y ☐N	Osteoporosis	☐Y ☐N	Tuberculosis	☐Y ☐N
Chemotherapy	☐Y ☐N	Heart Pacemaker	☐Y ☐N	Parathyroid Disease	☐Y ☐N	Tumors or Growths	☐Y ☐N
Chest Pains	☐Y ☐N	Heart Trouble/Disease	☐Y ☐N				

If you answered YES to any of the above, please explain: _____

_____

_____

Have you ever had any serious illness or condition not listed above? ☐ **Y** ☐ **N** **If YES, please explain:** _____

_____

_____

To the best of my knowledge, the questions on this form 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. I will not hold my dentist or any other member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ **DATE** _____

Doctor's Comments:

_____

_____

_____

_____

Office Use Only
BASELINE BP:

Initial:

License #:

Mauricio DosSantos DDS

Financial Policy

Thank you for choosing DosSantos Dental as your dental health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing a doctor

FULL PAYMENT OR INSURED PATIENT'S PORTION IS DUE AT TIME OF SERVICE

Payment for Services

For your convenience, we accept cash, checks, Visa, MasterCard, American Express or Discover Card. We also offer no interest payment plan through Care Credit & other outside financial groups (terms apply) and pre-payment courtesies. We will be happy to help you process your insurance claim forms at no additional cost and we will accept assignment of benefits where allowed. However, we must have your completed insurance form, copy of your insurance card and a provider benefit booklet at your first visit. The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied.

Account Balances older than 90 days and returned checks will be subject to an interest charge of 1.5% per month. There is a $30.00 charge for returned checks.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party of that contract.
2. Our fees are generally considered to fall within the acceptable range by most Companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, 80%) of "U.C.R." which means usual, customary and reasonable by most companies. (This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard of cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We must have a benefit booklet to help you determined your benefits.

Missed Appointments

Missed appointments without a 24 hour notice are subject to a charge minimum of $75. Our policy is to charge for missed appointments at the rate of a normal office visit. Please help us better serve you by keeping scheduled appointments.

Thank you for understanding our Financial Policy. We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Please let us know if you have questions or concerns.

I have read, understand, and agree to this Financial Policy.

_____ **Date** _____

Signature of Patient

_____ **Date** _____

Signature of Responsible Party

Mauricio DosSantos DDS

Permission to Share Information

We take your privacy seriously and are required by law to receive your permission to share any information regarding your account. You are not required to complete or sign this form. By completing this form you give permission to the staff and doctors at Mauricio DosSantos DDS to share the following records with the person(s) listed below.

Person(s) allowed to receive information:

_____

_____

Please check information you want to be accessible to person(s) listed:

- ☐ **All account/dental information**
- ☐ **Other**
  - ☐ **Financial**
  - ☐ **Treatment Plan**
  - ☐ **Previous Dental work**

We will continue to share the information listed with the person(s) you have listed until such time as you notify us otherwise. You may contact us at any time to have us discontinue sharing this information.

Print Name:_____

Signature:_____

Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement, however in refusing we will not be allowed to process your insurance claims.

I, _____, have received a copy of DosSantosDental Notice of Privacy Practices.

_____

[Please Print Name]

_____

[Signature]

_____

[Date]

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name

Relationship to Patient _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____