Luz DDS
GENERAL & COSMETIC DENTISTRY

Patient Information

Patient Name: _____ Nickname/Preferred Name: _____

Date of Birth: _____ Gender: □ Male □ Female Family Status: □ Single □ Married □ Child □ Other

Address: _____City: _____ State: _____Zip: _____

Phone: Home: (_____) _____ Work: (_____) _____Cell: (___) _____

Emergency name & Phone #: _____ Relationship to patient: _____

Email Address: _____

May we text and email your appointment reminders and information related to your dental treatment? □Yes □No

Whom May we thank for referring you to our Practice?

□ Friend/Family □ Internet/Website □ Insurance Directory □ Other: _____

Financial Information

Person responsible for payment: _____ Relationship to patient: _____

Employer Name: _____ Employer Phone: (____) _____

Name of Insured: _____ Date of Birth: _____

Insurance Company: _____ Phone: (____) _____

Insurance Address: _____

Group Number: _____ ID Number (SS#): _____

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most **comprehensive dental care** using the **highest quality materials and technology** available in the profession today. We are also committed to providing you with the up- to date- information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you.

All the charges you incur are your responsibility regardless of your insurance **coverage**. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer and the insurance company. Our practice is not a party to that agreement.

In consideration for the professional services rendered by this practice, payment is due in full at time of treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed.

As a courtesy to our patients, this office will help prepare dental insurance forms and assist in making collections from a primary insurance company. Your estimated copayment for treatment, which is the amount not covered by insurance, is due at the time treatment is provided. If payment is not received from your insurance company in 60 days from date of service, you will be expected to pay the balance in full.

Our practice accepts cash, personal checks, American Express, Master Card, Visa and Discover. Returned checks and any balance older than 60m days will be subject to finance charges at the rate of 1.5% per month. (18%annualy) on the unpaid balance and may result in collections.

Our practice requires 48 hours' notice to cancel an appointment. You will be charged a cancellation fee if you do not keep an appointment or cancel within 48 hours of appointment time you have reserved.

I have read the above conditions of treatment and payment and agree to their content. I authorize all insurance payments to be made directly to Dr. Luz Hernandez, DDS.

Signature of responsible party: _____ Date: _____

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Medical History

Patient Name: _____ Date of Birth: _____

Dental health is related to your overall health. Medical problems and medications impact your oral health and recommended dental treatment. To help ensure you have the optimum care, please answer the following questions below as accurately possible.

Are you currently under the care of a physician □ Yes □ No Please explain: _____

Physician Name: _____ Phone Number: _____

Have there ever been any changes in your health in the past year? □ Yes □ No Please explain: _____

Have you had a serious head or neck injury? □ Yes □ No Please explain: _____

Have you ever been hospitalized or had a major operation? □ Yes □ No Please explain: _____

Do you use tobacco (smoking, chew, snuff)? □ Yes □ No Are you interested in quitting? _____

Do you use drugs or controlled substances? □ Yes □ No Are you interested in quitting? _____

Have you had a total joint replacement? □ Yes □ No Type of joint (hip, knee, etc.): _____

Have you ever had infection or complications with your prosthetic joint? □ Yes □ No Please explain? _____

Do you have artificial heart valves? □ Yes □ No Please explain: _____

Has a physician recommended that you take antibiotics prior to dental treatment? □ Yes □ No Please explain: _____

_____

Women only, are you: Taking oral contraceptives? □ Yes □ No Pregnant/Trying to get Pregnant? □ Yes □ No Nursing? □ Yes □ No

Do You have, or have had any of the following?

□ Seasonal or Environmental Allergies	□ Dry mouth	□ Low Blood Pressure
□ Alzheimer's Disease	□ Emphysema	□ Nervous Disorders
□ Anemia	□ Epilepsy	□ Osteoporosis/ Osteopenia
□ Angina (Chest Pain)	□ Glaucoma	□ Pacemaker
□ Arthritis (Ra or Osteo)	□ Heart Attack/Heart Disease	□ Radiation Treatment
□ Asthma	□ Heart Murmur/ MVP	□ Respiratory Problems
□ Bleeding or Bleeding Problems	□ Hepatitis	□ Sinus Problems
□ Cancer	□ High Blood Pressure	□ Stomach Problems/ Ulcers
□ Chemotherapy	□ HIV/AIDS	□ Stroke
□ Diabetes (Type 1 or Type 2)	□ Immunosuppression	□ Thyroid Problems (Hyper, Hypo, Other)
□ Dizziness/Fainting	□ Kidney Disease	□ Tuberculosis
	□ Liver Disease	□ OTHER: _____

What **medications** are you taking? (Prescription and over-the- counter) _____

_____

Have you ever taken Fosamax, Actonel or Boniva (alendronate sodium, risedronate or ibandronate)? □ Yes □No

If yes, how long? _____ What form? □ Oral(pill) □IV

Do you have any **allergies?** □ Aspirin □ Acrylic □ Codeine □Latex □Metals □Penicillin Other: _____

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Dental History

Previous Dentist: _____ Date of last x-rays? _____

When was your last dental visit? _____ What was done? _____

Please check the following dental conditions that apply to you:

- ☐ Gums bleed when brush or floss
- ☐ Teeth sensitive to cold, hot, sweets or pressure
- ☐ Previous periodontal/ gum treatments
- ☐ Teeth are or feel loose
- ☐ Bad breath or Dry mouth
- ☐ Food collects between teeth
- ☐ Teeth have changed in the last 5 years, becoming shorter, thinner, or worn

Do you have any problems with your jaw joint?

- ☐ Pain
- ☐ Clicking or grinding sounds
- ☐ Limited opening
- ☐ Locking
- ☐ Popping

- ☐ Teeth are crowding or developing spaces
- ☐ Have more than one bite or clench/squeeze to make your teeth fit together
- ☐ Problems with sleep or wake up with an awareness of your teeth
- ☐ Snore or have a sleep disorder (apnea)
- ☐ Tension headaches or sore teeth
- ☐ Wear or have worn a bite appliance
- ☐ Problems chewing bagels or other hard foods

Do you currently have any?

- ☐ Dental Implants
- ☐ Full Dentures
- ☐ Partial Dentures
- ☐ Braces/ Invisalign

How do you feel about the appearance of your teeth? If you could change anything about your teeth, mouth or smile, what would it be?

_____

_____

I have answered the questions on this form to the best of my knowledge. I understand there may be a risk to my health or treatment if I do not fully disclose any medical or dental information. I understand it is my responsibility to inform this office of any changes.

Signature: _____ Date: _____

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Consent to Office Policy

The staff at Luz DDS is committed to providing outstanding dentistry. By consenting to the treatment recommended by the dentist, you are helping us to maintain an extraordinary level of care.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon me and to employ such assistance as to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that anesthetic agents embody certain risks. I understand that I can ask for a complete recital on any possible complications.

I understand that a treatment option is to receive no treatment. During the course of treatment, conditions not evident during examination may necessitate procedures different from those planned and may need a specialist for necessary treatment. I understand that I will be notified of any necessary treatment changes as well as cost differences. I understand any costs incurred from a specialist are my responsibility.

Photography is used as a means of communication between a dentist and patient, as well as other treating dentists/specialists and dental labs. Occasionally the doctors will use non-identifying photographs for educational purposes including study groups and case studies.

I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand the waiting on treatment needed may compromise the treatment initially proposed, which may necessitate more extensive treatment or procedures.

Notice of Privacy Practices (HIPAA)

We are required by law to maintain the privacy of the protected health information in your records and provide you with tis Notice of Privacy Practiced with respect to that information. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

There are certain circumstances under which we may use or disclose your health information without first obtaining your acknowledgement or authorization. These include treatment, payment, and health care operations.

Treatment: We may use or disclose your health information to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain pre-authorization or payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with operations such as quality assessment, public health and law- enforcement activities. We may also be required to report instances of suspected documented abuse, neglect or domestic violence. We must also provide health information when ordered by a court of law to do so.

Others Involved in Your Healthcare: We may disclose protected health information, including treatment plan, treatment alternatives, or payment information to a person or family member who is involved in your medical/dental care. If you do not wish this information to be shared, please notify the office. In addition, we may use your information to remind you of your appointment by sending e-mails, texts, postcards and /or leaving messages at home and/or work.

You have certain **rights regarding your health record information**. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We will consider your request but are not legally required to accept it. You have the right to inspect, copy and request amendments to your health records. You must submit a written request regarding the information you would like to inspect or amend. We will not alter our documents, but we will add your statement to your file. We will charge a reasonable dee for providing a copy of your health records. You have a right to receive a copy of this notice.

We reserve the right to change the terms of this notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this notice will be prominently displayed and available at our office. Please contact our office if you feel your privacy rights have been violated. More information is available at the U.S. Department of Health and Human Services website, http://www.hhs.gov/ocr/hipaa.

I have read the above information, have had the chance to have all my questions answered and I certify that I understand. I hereby give consent for treatment have chosen.

Signature: _____ Date: _____