CONFIDENTIAL

Patient Information

Patient Name: _____ Preferred Name _____ Gender:_____ Date: _____
Last, First MI

Birth Date: _____ Family Status: _____ Drivers License #:_____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Number: _____

Address: _____ Email Address: _____
Street Apt # City State Zip Code

Health Information

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING: _____

_____

Have you ever had any of the following? Please check YES or NO:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Allergies:_____	☐	☐	Blood Transfusion	☐	☐	Heart Lesion	☐	☐	Recent Weight Loss
☐	☐	Allergy: Aspirin	☐	☐	Bruise Easily	☐	☐	Heart Trouble	☐	☐	Respiratory Problems
☐	☐	Allergy: Amoxicillin	☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever
☐	☐	Allergy: Clindamycin	☐	☐	Chemotherapy	☐	☐	Heart Surgery	☐	☐	Rheumatism
☐	☐	Allergy: Codeine	☐	☐	Chest Pain	☐	☐	Hemophilia	☐	☐	Scarlet Fever
☐	☐	Allergy: Epinephrine	☐	☐	Cold Sores	☐	☐	Hepatitis A/B/C	☐	☐	Shortness of Breath
☐	☐	Allergy: Flagyl	☐	☐	Cortisone Medicine	☐	☐	Herpes	☐	☐	Sickle Cell Anemia
☐	☐	Allergy: Ibuprofen	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Sinus Problems
☐	☐	Allergy: Latex	☐	☐	Dizziness	☐	☐	Low Blood Pressure	☐	☐	Stomach Problems
☐	☐	Allergy: Penicillin	☐	☐	Drug Addiction	☐	☐	Hypoglycemia	☐	☐	Stroke
☐	☐	Allergy: Sulfa Drugs	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Swelling: feet/hands
☐	☐	Allergy: Tetracycline	☐	☐	Epilepsy or Seizures	☐	☐	Kidney Disease	☐	☐	Thyroid Disease
☐	☐	Allergy: Tylenol	☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Allergy: Vicodin	☐	☐	Excessive Thirst	☐	☐	Lung Disease	☐	☐	Tumors
☐	☐	AIDS or HIV	☐	☐	Fainting	☐	☐	Mental Disorders	☐	☐	Ulcers
☐	☐	Alzheimer's	☐	☐	Fever Blisters	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease
☐	☐	Anemia	☐	☐	Frequent Cough	☐	☐	Nervous Disorders	☐	☐	Actone (Risedronate sodium)
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Pacemaker	☐	☐	Aredia (Pamidronte Sodium)
☐	☐	Artificial Joints	☐	☐	Growths	☐	☐	Pain in Jaw Joint	☐	☐	Fosamax (alendronate)
☐	☐	Artificial Heart Valve	☐	☐	Hay Fever	☐	☐	Psychiatric Care	☐	☐	Phen Phen or Redux
☐	☐	Asthma	☐	☐	Head Injuries	☐	☐	Radiation Therapy	☐	☐	Zometa (zoledronic acid)
☐	☐	Blood Disease	☐	☐	Heart Disease	☐	☐	Radiation Treatment	☐	☐	_____

Note to Women: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

Women: Are you pregnant? ☐ **No** ☐ **Yes** **If Yes, Due:** _____

- **Name of Physician**: _____ **Phone**: _____
- Have you ever had any complications following dental treatment? ☐ No ☐ Yes 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? ☐ No ☐ Yes If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ No ☐ Yes If yes, please explain: _____

In case of emergency, whom shall we call: Name _____ **Relationship**_____

Phone Numbers: _____

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, or if my medicines change, I will inform the doctors at the next appointment without fail.

X_____ Date: _____
Signature of patient, parent or guardian

Reviewed by Dr:_____ **Date:**_____ **Reviewed by Dr:**_____ **Date:**_____
Reviewed by Pt:_____ **Date:**_____ **Reviewed by Pt:**_____ **Date:**_____

Consent for Services

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients 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 service performed without prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or her staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing **if** credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

IT IS OUR POLICY TO CHARGE $15.00 PER 15 MINUTES FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE. THIS FEE MUST BE PAID PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS

I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

X_____ **Date:** _____

Signature of Responsible Party / Parent or Guardian

Relationship to Patient: _____

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims:

X_____

Signature of Responsible Party/Parent or Guardian

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr. Maria Luisa C. Vales, DMD:

X_____

Signature of Responsible Party/Parent or Guardian

Maria Luisa C. Vales, D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

Name of Patient: _____ **Date of Birth:** _____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. If you have any further questions regarding the Health Insurance Portability Accountability Act, please refer to the HIPAA web-site: **http://www.hhs.gov/ocr/hipaa/finalreg.html**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, specialty referrals, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I, _____, have received acknowledgement of this office's Notice of Privacy Practices and have had full opportunity to read and consider the contents of this Consent form. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, specialty referrals, and health care operations.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

Acknowledgement of Receipt and Consent:

Signature X_____ **Date**_____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

Please list any family members or friends that we may discuss your dental needs, treatment and/or financial, and appointments with:

_____

You May Refuse to Sign This Acknowledgement*

REVOCATION OF CONSENT

Right to Revoke: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, specialty referrals, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature _____ Date_____

For Office Use:

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)

_____

_____

Send to Dr. Vales