PATIENT REGISTRATION FORM

PATIENT INFORMATION **Date** ______________

(Please print)

Patient Name: ____ **Date of Birth:** _______________
Last First

Address: ____
Street City Apt or Lot # Zip Code

Home Tel#: __________________ **Work#:** __________________ **Cell#:** ______________________

Social Security#: ____________________ **Marital Status**: ______________ **Sex:** ______________

Referred By: ____

E-mail: _________________________________ **Local Pharmacy#:** ___________________________

Dental Insurance: ______________________________ **Phone#:** ___________________________

PARENT INFORMATION (if patient is a MINOR)

Mother's Name: ______________________________ **Social Security#:** _____________________

Address: _________________________________ **Home#:** _______________ **Cell#:** ___________

Father's Name: ______________________________ **Social Security#:** _______________________

Address: ________________________________ **Home#:** _____________ **Cell#:** _____________

PATIENT EMPLOYER

Employer's Name: ___________________________ **Occupation:** ____________________________

Employer Address and Phone#: ____

IN CASE OF AN EMERGENCY. WHO DO WE NOTIFY?

Name: ____________________________________ **Relationship:** ____________________________

Address and Phone#: ____

IMPORTANT: **How would you like to be contacted?** ______ **Text** ______ **E-mail** ______ **Phone**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

In order to provide you with the best quality care, we may need to contact you or an authorized person regarding your treatment and/or appointments. Please list who we may contact aside from you regarding these matters.

Who may we share appointment, treatment and financial information with?

Name: ______________________ Phone: ________________ Relation: __________

Name: ______________________ Phone: ________________ Relation: __________

May we contact you at: Work __________, Cell _______________, Home, _______________

Regarding the Above?

May we leave a detailed message at Work __________, Cell __________, Home, __________

I, _________________________________ understand the Privacy Practices.

I understand that if I wish to read the entire Notice of Privacy Practices a copy will be given to me.

Date: ________________________

Patient Name: ___________________________________

Patient Signature: ___________________________________

For Smiles - Health History

Name: ____ **Date:** ____________________

Date of last health exam: ___________________ **What was this exam for?** ____________________

Have you been hospitalized in the last 5 years? □ No □ Yes
If yes, reason: ____

Are you currently receiving care? □ No □ Yes If yes, nature of care: ____________________

Please list all name and phone numbers of the physicians who are currently providing you care:

1.____
2.____
3.____
4.____

For the following questions circle **Yes** or **No**. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur(mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV positive or AIDS related complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Kidney Disease	No	Yes	Liver Disease (including Jaundice)	No	Yes
Heart(Surgery ,Disease , Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	H.I.V infections/AIDS	No	Yes

Are You Required to Pre-medicate before dental treatment? □ No □Yes

Woman: Are you pregnant? □ No □Yes
If no, are you planning a pregnancy in the near future? □ No □Yes
Are you a nursing mother? □ No □Yes
Are you on birth control pills? □ No □Yes

Abnormal Blood Pressure? □ No □Yes

If yes, what is it usually : S /D

Are you allergic or have you had a reaction to:

a. Local anesthetics
b. Penicillin or other antibiotics
c. Aspirin
d. Codeine, valium or other sedatives

e. Other____

Health History Continued……..

Are you a smoker? □ No □Yes
If so, how much do you smoke per day? ____

Do you consume grapefruit juice, grapefruits or grapefruit extract? □ No □Yes

Please list any medications you are currently taking: (please provide copy of medication list if longer than the space provide).

1.________________________________ 2.________________________________

3.________________________________ 4.________________________________

5.________________________________ 6.________________________________

Are you taking Tagaget (Cimetidine)? □ No □Yes If yes, how often? ______________
Do you take antacids? □ No □Yes If yes, how often? ______________

Are you taking herbal supplements/medicines? □ No □Yes If yes, how often?______________

Diet: Restricted Diet__________________________________
How many meals a day____________________________
Food Allergies___________________________________
Sugar in your diet: None Slight Moderate High

Dental History:

Date of last Dental Check-up____

Why have you come to the dentist today? ____

Previous Dentist____

Reason for leaving last dentist____

I understand all the above the information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all questions to the best of my knowledge.
Should further information be needed, you have my permission to ask all the respective health care provider or agency, who may release such information to you.
I will notify the doctor of change in my health and medication.

______________________	______________________	______________
Patient (PRINT NAME)	Patient Signature	Date
______________________	______________________	______________
Doctor (PRINT NAME)	Doctor Signature	Date

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FINANCIAL POLICY

Our office **DOES NOT EXTEND CREDIT**. We do not "bill" the patient. . We do however, offer several options for methods of payment so you can choose the one which suits your personal situation.

A. METHOD OF PAYMENT:
1. Credit Cards: Visa, MasterCard, Discover, Amex.
2. Cash
3. Care Credit (payment plan)

B. DENTAL INSURANCE:

C. (Our office cannot be held responsible for our estimate of your benefits)
Your estimate Co-payment is due when treatment is rendered.
IF FOR ANY REASON YOUR INSURANCE COMPANY HAS NOT PAID WITHIN 30DAYS, THE ENTIRE BALANCE BECOMES DUE AND PAYABLE BY YOU.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to be made directly to Dr. Esther Santana for benefits, which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. Our office is not contracted directly with any insurance plan.
I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to the above named doctors.

NOTICE OF HIPAA PRIVACY FORMS:

I have read the offices notice of privacy practices.

X-RAY EXAMINATION (FOR FEMALES ONLY):

I am aware that the radiation exposure may be harmful to an unborn child.
To the best of my knowledge, I am not pregnant at the time. I agree to diagnostic X-ray examinations as requested by Dr. Santana: Dr. Fernandez-Carol: Dr.Cinton: Dr. Morales: Dr.Santani: Dr. Kaouk.

PHOTOGRAPHS AND FILMS:

I further agree to the taking of photographs, films, or other materials showing the condition of my mouth or my treatment for the purpose of documentation, my education or the showing to the public at large or the other display of such photographs, films or other materials including dental records X-rays if necessary for dental, scientific and educational purposes.

THE ABOVE UNDERSIGNED CERITIFIES THAT HE/SHE HAS READ AND UNDERSTANDS EACH OF THE ABOVE PARAGRAPHS AND IS THE PATIENT OR RESPONSIBLE PARTY WITH THE POWER TO EXECUTE THIS DOCUMENT AND ACCEPT THESE TERMS.

Signature of Patient or Responsible Party______________________________ Date: __________

Signature of Witness____ Date: ________________

APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to you and the rest of our patients.

In an attempt to be consistent with this, we have a *Appointment Cancellation Policy* that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient. Dental procedures require preparation, treatment room availability and material preparation at specific times during our work day.

Our policy is as follows:

______ (initial) We require that you give our office 24 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment.

<u>**A fee of $25.00</u> will be charged to you; this fee *cannot* be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred with out the payment of this fee.

-Family emergencies will be taken into consideration-

OUR APPOINTMENT POLICY

______ (initial) Please arrive on-time to your scheduled appointment. Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day. Our office policy is firm in this regard

WE THANK YOU FOR YOUR PATRONAGE.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have

I have read and understand the Appointment Cancellation & Appointment Policy of the ractice.

Patient Name (***Printed***):_________________________

Patient Signature: ______________________________

Date: ______________________________

OSTEONECROSIS OF THE JAW - RISK ACKNOWLEDGEMENT

Patients taking bisphosphonate medications may be at an increased risk for developing a serious condition termed "osteonecrosis of the jaw" (ONJ). While most of the reported cases of ONJ involve patients taking the intravenous (I.V.) form of the medication, ONJ has occurred less frequently in patients who are taking the oral form of bisphosphonate medications. These medicines are usually prescribed by the physician for prevention and treatment of osteoporosis.

EXAMPLES OF BISPHOSPHONATE MEDICATIONS (NOT A COMPLETE LIST)

Brand Name	***Generic Name***
Actonel	risedronate
Boniva	ibandronate
Fosamax	alendronate
Fosamax Plus D	alendronate
Skelid	tiludronate
Didronel	etidronate
Zometa	zolendronate

Osteonecrosis of the jaw (ONJ) describes a condition that can develop in the absence of dental treatment, or it can occur during or following dental treatment. ONJ can cause severe, irreversible and often debilitating damage to the jaw. ONJ may result in pain, soft-tissue swelling and infection, loosening of teeth, drainage, and exposed bone. Pain and infection may or may not be present. ONJ may remain asymptomatic (no noticeable symptoms) for weeks or months and may only become evident after the finding of exposed bone in the jaw during routine examination. ONJ can occur spontaneously but is more commonly associated with dental procedures that affect the bone, such as dental extractions. Older age (over 65 years), oral glucocorticoid use for chronic conditions, periodontitis (gum disease), and prolonged use of bisphosphonates have been associated with an increased risk for bisphosphonate-associated osteonecrosis or ONJ. <u>There is no effective treatment or cure for this condition.</u>

As each patient's dental situation is different, different factors have to be considered for the individual patient when weighing the risks versus the benefits of proceeding with any given dental treatment. Each patient's case will be considered individually, and a treatment plan will be suggested taking into account the patient's need for dental/surgical treatment and the patient's individual risk for developing the ONJ complication. Alternative dental treatment plans may exist to lessen the risk of ONJ and may include less comprehensive/extensive treatment or no dental treatment at all.

I have read this document and understand that risks for osteonecrosis of the jaw (ONJ) exist for patients who take medications of the bisphosphonate class. I have discussed the risks and benefits for the proposed treatment with my dental care provider and have considered alternative dental treatments. I have read the attached American Academy of Periodontology "Statement on Bisphosphonates". I have also been advised to discuss the risks of ONJ with my physician who prescribed the medicine to obtain his or her advice.

____ ____________________

Patient's or Legal Representative's Signature *Date*

Sleep Health Questionnaire

Please fill out this questionnaire to help us evaluate your sleep health.

Patient:______________________________ **Date:** _________________

Have you been told that you snore?	Y	N
Are you tired throughout the day?	Y	N
Do you have morning headaches?	Y	N
Do you suffer from insomnia?	Y	N
Do you wake up gasping for air?	Y	N
Have you ever had a Sleep Test?	Y	N
Have you been Diagnosed with Sleep Apnea?	Y	N
Do you use CPAP machine?	Y	N

Thank you we are always concerned about your overall health.