Patient Name:_____ **Date:**_____

PRIMARY PHYSICIAN INFORMATION

Physician: Telephone:

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? _____
☐Y☐N Any serious illnesses/surgeries? _____
☐Y☐N Use tobacco in any form? If Yes, Type: _____
☐Y☐N **Is pre-medication required before dental visits due to heart condition or artificial joint?**
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

_____

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

_____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CHICKEN POX
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT EAR INFECTIONS
☐FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐PACEMAKER
☐OTHER – PLEASE LIST: _____
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐CODEINE
☐DAIRY
☐LATEX
☐SULFA DRUGS
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐PENICILLIN/OTHER ANTIBIOTICS
☐OTHER – PLEASE LIST: _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER (PLEASE LIST BELOW)
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐TRANQUILIZERS
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS

CONTINUE ON THE BACK

If taking any medications list below if not please leave blank.

PATIENT NAME:	DATE:
DRUG NAME	REASON PRESCRIBED

Patient Signature: _____ **Date:**_____

Staff Signature: _____ **Date:**_____

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Dental Insurance Information

Thank you for choosing the office of Dr.Alvarez. We will be happy to help you file your dental insurance claims. We understand that dental insurance can be very confusing and will be happy to answer your questions to the best of our ability. Remember that we are here to serve you.

Please help us by reading and acknowledging the following:
Some insurance carriers limit the procedures they will cover. Please be assured that Dr.Alvarez will always recommend the treatment that is appropriate for your health, regardless of what an insurance company representative will approve.

We will ESTIMATE your deductible and the amount covered on dental procedures.
Please remember that this is only an estimate based on our history with your insurance company. If they should cover less than expected, you will be responsible for the balance. If they cover more, a credit will be applied to our account or a prompt refund will be mailed, depending on your preference.
The insurance is a contract between you, your employer and the insurance carrier. We are not a party to that contract. We will make every effort to provide all the information to expedite the claim, but ultimately any uncovered procedure is the patient's responsibility.

Please keep us informed if any treatment has been performed at another dental office so that we can more accurately estimate your remaining benefits.
Please let us know if there have been any changes in your employment or insurance that might affect your benefits. Thank you for reviewing our insurance policy. We want to avoid misunderstandings so that we may focus on your health.
I understand and accept Dr.Alvarez's policy on dental insurance.

_____ _____

Patients Guardian / Signature **Date**

Missed appointment policy

Courtesy calls are made when possible; however it is the patient's responsibility to remember their dental appointments. Please check the bottom of your statement of services rendered to confirm all family appointments. If you call to make an appointment, please make sure to document the day and time it has been scheduled. **We do require a 2 working day advance notice to cancel an appointment in order to avoid being charged a $50.00, per hour cancellation fee.**

All fees are due at time of service. Should this matter be turned over to collections, all cost including reasonable collection fees (50%) and court cost incurred by Dr. Jorge Alvarez, DDS, shall be borne by undersigned.

_____ _____

Patients Guardian / Signature **Date**

HIPPA Agreement

HIPPA consent to use protected health information for treatment, payment and health care operations.

I consent to allow Dr. Jorge Alvarez DDS., P.C. to use or disclose my protected health information for treatment, payment and health care operations.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers. Payment means the activities undertaken by a health care provider or health plan to obtain or provide insurance reimbursement for the provision of health care.

Health care operations mean conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Jorge Alvarez DDS., P.C.

I consent to allow Jorge Alvarez DDS., P.C. to disclose protected health care information to another provider for health care operations activities, provided that the other health care provider has or had a relationship with the below named patient. The disclosure must be for the treatment or other health care operations or for the purpose of health care fraud and abuse detection or compliance. I understand that the information in my dental record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services.

_____ _____

Patients Guardian / Signature **Date**