Patient Information

Name:_____ Soc. Sec. # _____-_____-_____

Address _____ Email _____

City_____ State_____ Zip_____

Sex: ( ) M ( ) F Birthdate _____ ( ) Single ( ) Married ( ) Divorced ( ) Other

Home phone _____ Mobile phone _____

Patient employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified?_____ Phone _____

Primary Insurance

Person Responsible for the Account_____

Relation to Patient_____ Birthdate _____

S.S # _____ Address (if different from patient) _____

Home phone_____ City _____ State_____ Zip _____

Business Address _____ Business Phone _____

Insurance Company_____ Group #_____

I.D. #_____ Subscriber S.S. #_____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with above mentioned insurance company and assign directly to Dr. Julio A. Rodriguez all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship to patient Date

Name:_____ **Date:**_____

Dental History (Confidential)

Reason for Today's visit: _____

Would you be interested in a consultation for : ☐ Botox ☐Fillers ☐Vampire Facial ☐PRP for Hair ☐ Meyers IV Vitamin Infusion?

Former Dentist: _____

Date of last dental: _____ Date of last dental X-ray: _____

How often do you floss? _____ How often do you brush? _____

Circle yes or no if you have had problems with any of the following:

Bad breath	Y	N	Grinding teeth	Y	N
Bleeding gums	Y	N	Loose teeth or broken fillings	Y	N
Clicking or popping of jaw	Y	N	Periodontal treatment	Y	N
Food collection between teeth	Y	N	Sensitivity to hot/cold or sweet	Y	N
Sores or growths in your mouth	Y	N	Do you snore?	Y	N

Medical History

- Have you been examined or treated by a physician in the last year? ❒ YES ❒NO
  If yes, for what reason? _____
  Physician's Name _____ Date of last visit_____
- Have you had any type of surgery or outpatient procedure in the past year? ❒YES ❒NO
  If yes, for what reason? _____
  Type of anesthesia:_____Complications:_____
- Have you been to the E.R. or Urgent Care Facility in the past year? ❒YES ❒NO
  If yes, for what reason _____
- Have you been hospitalized in the past year? ❒YES ❒NO
  If yes, for what reason _____
- Have you ever had a blood transfusion? ❒YES ❒NO
  If yes, when? _____
- Have you had any unusual bleeding in the past year? ❒YES ❒NO
  If yes, please describe:_____
- In the past week have you taken any recreational or medicinal drugs? ❒YES ❒NO
  If yes, then what? _____

Do you smoke? ☐ YES ☐ NO How much? _____

Do you drink Alcohol? ☐ YES ☐ NO How much? _____

(Women Only)
Are you pregnant? ❒YES❒NO Nursing? ❒ YES ❒ NO Taking birth control pills? ❒ YES ❒ NO

Name:_____ **Date:**_____

Medical History continued….

Please Circle Yes or No

ADD	Y	N	COVID 19	Y	N	Osteoporosis	Y	N
Aids	Y	N	Diabetes	Y	N	Pacemaker	Y	N
Anemia	Y	N	Epilepsy	Y	N	Psychiatric Care	Y	N
Anxiety	Y	N	Elevated Cholesterol	Y	N	Radiation Treatment	Y	N
Arthritis, Rheumatism	Y	N	Emphysema	Y	N	Respiratory Disease	Y	N
Artificial Heart Valves	Y	N	Fainting	Y	N	Rheumatic Fever	Y	N
Artificial Joints	Y	N	GERD/Reflux	Y	N	Scarlet Fever	Y	N
Asthma	Y	N	Glaucoma	Y	N	Shortness of Breath	Y	N
Back Problems	Y	N	Hepatitis	Y	N	Skin Rash	Y	N
Bleeding Problems	Y	N	Headaches	Y	N	Stroke	Y	N
Blood Disease	Y	N	Heart Murmur	Y	N	Swelling of the feet or ankles	Y	N
Bronchitis	Y	N	Heart Problems	Y	N	Thyroid Problems	Y	N
Cancer	Y	N	High Blood Pressure	Y	N	Tonsillitis	Y	N
Chemical Dependency	Y	N	HIV Positive	Y	N	Tuberculosis	Y	N
Chemotherapy	Y	N	Jaw Pain	Y	N	Ulcer	Y	N
Chest Pain	Y	N	Kidney Disease	Y	N	Venereal Disease	Y	N
Circulatory Problems	Y	N	Liver Disease	Y	N	Other		
Cortisone Treatments	Y	N	Mitral Valve Prolapse	Y	N			
Cough, persistent	Y	N	Obstructive Sleep Apnea		N			

If other, please explain: _____
_____
_____

Please list all **medications**, including medical prescriptions (**RX**), over the counter (**OTC)** or supplements that you have taken in the past month. Please include dosage, frequency and the reason for taking them.

Medication	Dosage	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please Select any Allergies you may have:

☐No Allergies ☐Aspirin ☐Barbiturates (sleeping pills) ☐Codeine ☐Local Anesthetic ❒ Latex ☐Penicillin
☐Sulfa ☐Other _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ____/____/_____ Signature _____ ❒Patient ❒Parent ❒ Guardian

Patient Acknowledgement of Receipt of the Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. I hereby consent to the use and disclosure of my health information for the purposes and the activities under the federal privacy law. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the office.

_____ _____

Patient's Name (Please print) Date

_____

Signature (if minor Parent or Guardian)

_____

Patient's Legal Representative (if applicable)

_____

Signature of Legal Representative

Dental Arts of Sunset
Office Policies 2022

1) All fees will be explained to patient along with the proposed treatment plan before any services are commenced. Fees are to be paid in full at the time of service.

Initial _____

2) Sometimes during treatment the plan may have to be modified at the Doctors discretion to account for any complications that may have been unforeseeable. Procedures may have to be added or omitted. No new procedures will be commenced without disclosing any additional fees to patient.

Initial _____

3) Accounts 30 days past due will incur finance charge of 1.5% per month. Accounts 60 days past due will be turned over to either collection agency or attorney.

Initial _____

4) In the event that collection or court proceedings are necessary to collect sums due and owing to us, the patient agrees to be fully responsible for the payment of all attorneys' fees and costs in connection with the proceedings (due to returned checks or otherwise).

Initial _____

5) Your appointment time is RESERVED exclusively for YOU. We NEVER double book patients. This allows us to run on time and more importantly it allows YOU to run on time without annoying waits. In order to accomplish this we cannot tolerate broken appointments. If you have an appointment with us and your plans change we require 48 hours advance notice, or as soon as possible, in case of an emergency so your appointment will not be considered "BROKEN". Any patient who breaks an appointment will be charged a $50/hour.

Initial _____

6) **Patients with insurance**. We will be happy to file on your behalf. We will also try to estimate what they may cover. Our estimates are based on a telephone conversation with an operator at your insurance company. This is **NOT A GUARANTEE OF BENEFITS** and we cannot be responsible for the terms/limitations and exclusion of your particular plan. We encourage you to become familiar with the fine print of your plan. Patients will be required to pay in full any claims not paid by the insurance carrier within 30 days and any remaining balance if the insurance pays less than what was estimated.

Initial _____

7) This agreement, when signed by both parties, is a legal and binding contract and supersedes all other agreements including oral, written, past or present.

Initial _____

_____ _____

Patient or Guardian Office Representative

_____ _____

Date Date

Payment Options

1. Cash
2. Credit Card- Visa, Master Card, American Express, Discover Card
3. Personal Check: Processed through TeleCheck
4. DEBIT/ATM Card
5. Third party financing Companies: Care Credit

I have Read and understand the payment options of this office.

_____

Patient or Guardian Signature

_____

Date