Herrera
FAMILY DENTAL

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will gladly help. We look forward to working with you in maintaining your dental health.

Patient Information

Patient name: _____

Name of Legal Guardian if patient is a minor:_____

Address:_____

City:_____ State:_____ Zip Code _____ Home phone:_____

Cell phone:_____ Email:_____

Sex: □ M □ F Age:_____ Birthdate:_____/_____/____ Social Security:_____

Whom may we thank for referring you? _____

Notify in case of emergency: _____ contact phone #:_____

Primary Insurance

Person responsible for Account:_____

Relation to Patient:_____ Birthdate:_____ Soc.Sec.#:_____

Address (if different from patient):_____ Phone: _____

City:_____ State:_____ Zip code:_____

Insurance Company:_____ Phone:_____

Group #:_____ Subscriber's #:_____

Name(s) of other dependents on this plan: _____

Additional Insurance

Is patient covered by additional insurance? □ Yes □ No

Subscriber's Name: _____ Relation to Patient:_____ DOB: _____

Address (if different from patient): _____ Soc. Sec #:_____

City:_____ State:_____ Zipcode:_____ Home Phone:_____

Insurance Company:_____ Phone:_____

Group #:_____ Subscriber's #:_____

Dental History

What would you like us to do today?:_____

Are you having dental discomfort?:_____

Date of last dental care:_____ Date of last X-rays:_____

Bad Breath Sensitivity to sweets Sensitivity to hot/cold Sensitivity when biting Loose teeth or Broken Fillings
Food Collection between teeth Bleeding gums Periodontal treatment Grinding/Clenching teeth Clicking/Locking jaw

Please circle any of the following that you have had:

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

On a scale of 1-10, how important is your smile? 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10, how would you rate your smile? 1 2 3 4 5 6 7 8 9 10

Are you interested in teeth whitening?

_____

Are you interested In Invisalign? _____

Are you interested in Implants?_____

Medical History

Are you currently under physician care? _____ If yes, describe:_____

Have you ever taken Bisphosphonates/Osteoporosis medicine?_____

Have you ever taken blood thinners?_____

Have you ever had cancer or radiation treatment?_____

Women: Are you pregnant? _____Are you nursing?_____ Taking Birth Control?_____

Please circle if you have any of the following:

AIDS/ HIV positive Back problems Cough up blood Heart problems:_____

Anaphylaxis	Blood disease	Diabetes	Hemophilia/Abnormal bleeding
Anemia	Cancer	Epilepsy	Herpes
Arthritis, Rheumatism	Chemical dependency	Fainting	Fever
Hepatitis __ A __ B __ C __ E			
Artificial heart valves	Chemotherapy	Food allergies	High blood pressure/Heart Disease
Artificial joints	Circulatory problems	Glaucoma	Jaw Pain
Asthma	Cortisone treatments	Headaches	Kidney disease or malfunction
Atopic (allergy prone)		Cough, persistent	Heart murmur
Material allergies (latex, wood, metal,chemicals)		Mitral valve prolapse	Nervous problems
Osteoporosis		Liver Disease	COVID19
Pacemaker/Heart surgery		Psychiatric care	Rapid weight gain or loss
Radiation treatment		Respiratory disease	Rheumatic fever
Scarlet fever		Shingles	Shortness of breath
Skin rash		Spina Bifida	Stroke
Surgical Implant		Swelling of feet or ankles	Thyroid disease or malfunction
Tobacco habit		Tonsillitis	Tuberculosis
Ulcer/Colitis		Venereal disease	Other:_____

List medications you are currently taking, if any:

_____ _____

_____ _____

_____ _____

List drug allergies, if any:

_____ _____

Health History Update

Are there any updates to your health history?_____

_____

HIPAA Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by my dentist to help determine appropriate and healthful dental treatment. If there is any changes in my medical status, it is my responsibility to inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

Payment is due in full time of treatment unless prior arrangements have been approved

Welcome to *Herrera* Family Dental

We realize you have many choices for your dental care and do appreciate you choosing our office for your dental needs. At Herrera Family Dental, we are committed to providing you with the highest quality, state of the art dentistry, in a manner that is comprehensive, compassionate, and cost-effective.

_____PAYMENTS **(please initial)**

Payments are due at the time of service. For your convenience, in addition to cash we accept Visa, MasterCard, Discover Card, and American Express. Interest free financing for those who qualify may be applied for through one of the several financing programs we have to offer. Our staff can help you with the application.

_____INSURANCE **(please initial)**

Unfortunately, there is a great deal of confusion about dental insurance. Please remember that we do not work for any insurance company or for any PPO or HMO. **WE WORK FOR YOU.** Our treatment recommendations are based solely on our professional knowledge of what will give you the best outcome. Insurance companies' treatment recommendations are based solely on what is best for their profit margins. While we are not directly involved with any insurance company, we will do all we can to help you receive maximum benefits. For all procedures, a claim will be submitted on your behalf to your insurance company. We will follow up with the insurance company and re-bill if necessary. However, if we do not get paid in 45 days from the date of service, the balance will be your responsibility. At this time, we may ask for your help to call your insurance company to help resolve any outstanding issues. Our staff members work hard to help patients maximize their benefits from their insurance company.

_____CANCELLATIONS PLEDGE **(please initial)**

We understand that on any occasion cancellations are necessary, particularly due to illness. However, please remember that your appointment time is reserved exclusively for you, and without adequate time to fill the broken appointment, the operatory is empty. Please notify within at least 48 hours if you are unable to make it to your appointment. The 48 hours will allow us to reschedule this appointment with someone else. This policy helps us keep our operating costs as low as possible for all our patients. If patients have a record of 2 or more missed appointments, we may hesitate to reschedule. For this reason, we will schedule a time that is most convenient for you. We do understand that life happens and things change, we only ask for open and honest communication regarding those changes.

_____X-RAYS/PHOTOGRAPHY **(please initial)**

Your initial visit will consist of a comprehensive oral evaluation and a full-mouth set of X-rays AND photos.(FMX) Insurance plans may not pay for the FMX. If your insurance denies all or part of the X-rays, you may be responsible for the difference. X-rays are necessary in the diagnosis and treatment of patients. Refusal to allow necessary X-rays to be taken may result in the doctor refusing to diagnose or perform treatment until the needed X-rays are obtained. Photos may be taken to properly document your case. We are striving for the best, and photography allows us to continue improving and help others learn. Documented cases may be used in the future for learning purposes or presentations. No personal information will be included.

I have read and understand the office and cancellation policy

Name: _____ Date:_____

Signature: _____

Information Sharing Consent Form

I, _____, give my permission to share information concerning:

- My dental treatment
- The cost and financial arrangements for my dental treatment
- My personal health information
- Other: _____

I give permission to share the above noted information with

- My spouse (name) _____
- My parent(s) (names) _____
- My adult child or children (names) _____
- Other: _____

I, _____, DO NOT give my permission to share ANY information regarding my treatment, financial arrangements or personal information with the exceptions of what is outlined in the Notice of Privacy Practices.

Signature: _____ Date: _____