

Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.
 If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Patient Number _____
 Date _____
 SS#/SIN _____ Birthdate _____ Home Phone _____
 State/Prov. _____ Zip/PC. _____
 Address _____ City _____
 Email _____ Cell Phone _____
 Check Appropriate Box: Minor Single Married Separated Divorced Widowed
 If Student, Name of School / College _____ City _____ Full Time Part Time
 Patient or Parent/Guardian's Employer _____ Work Phone _____
 Business Address _____ City _____ State/Prov. _____ Zip/PC. _____
 Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
 Whom May We Thank for Referring You? _____
 Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
 Address _____ Home Phone _____
 Email _____ Cell Phone _____
 Driver's License # _____ Birthdate _____ Financial Institution _____
 Employer _____ Work Phone _____ SS#/SIN _____
 Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ SS#/SIN _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Employer Address _____ City _____ State/Prov. _____ Zip/PC. _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/PC. _____
 How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit? _____

Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ SS#/SIN _____ Date Employed _____
 Name of Employer _____ Union or Local # _____ Work Phone _____
 Employer Address _____ City _____ State/Prov. _____ Zip/PC. _____
 Insurance Company _____ Group # _____ Policy/ID # _____
 Ins. Co. Address _____ City _____ State/Prov. _____ Zip/PC. _____
 How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit? _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?
If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you allergic to or have you had any reactions to the following? | | |
| 3. Are you taking any medication(s) including non-prescription medicine?
If yes, what medication(s) are you taking? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (e.g. Novocain) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have or have you had any of the following? | | | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Any Metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 13. Women Only: | | |
| | | | Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Are you taking oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist _____ Date of Last Exam _____
 Previous Dentist's Location _____ Date of Last Cleaning _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you wear dentures or partials?
If yes, date of placement _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Difficulty in chewing | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X
 Signature of patient (or parent/guardian if minor) _____

Doctor's Comments _____

 Signature _____ Date _____



Notice of Privacy Practices

Patient Acknowledgement

Patient Name: _____ Date Of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my Protected health information that may be made by this practice, my individual rights and the practice' legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
• A statement that this practice is required to abide by the terms of notice currently in effect.
• Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
• A description of each of the other purposes for which this practice is permitted or requested to use or disclose protected health information without my written consent is authorized.
• A description of uses and disclosures that are prohibited or materially limited by law.
• A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
• My individual right with respect to protect health information and a brief description of how I may exercise these rights in relation to:
I. The right to complain to this and to the Secretary of HHS if I believe my privacy rights have been violated, and that no Retaliatory actions will be used against me in the event of such a complaint.
II. The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
III. The right to receive confidential communications of protected health information.
IV. The right to inspect and copy protected health information.
V. The right to amend protected health information.
VI. The right to receive an accounting of disclosures of protected health information.
VII. The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to Patient (If signed by a personal representative of patient): _____



Gentle Touch Dental

Angelica Isaza, D.M.D.

CANCELATION AND RE-SCHEDULING POLICY

We have convenient office hours to serve our patients and we reserve appointment time exclusively for each patient. We will work with you to schedule appointments that maximize your care in the shortest number of appointments.

When we reserve an appointment for a patient, that patient is the only one scheduled at that time for either the doctor or the hygienist. The focus of the doctor or the hygienist is only on that patients' care and the time allowed is very important. Each appointment in a patients' treatment schedule moves that person closer to completing his or her needed dentistry.

I am sure you understand that we must have guidelines regarding cancellations. Our policy is that all appointment changes must be 48 hours in advance to allow us time to schedule other patients who are waiting for necessary treatment. Without notice, we do charge \$50 for last minute cancellations.

We hope in the future that you will give us the notice that allows us flexibility. More importantly, we hope you can keep your scheduled appointments so that together we can complete your necessary dentistry. I look forward to seeing you at your next appointment.

THANK YOU FOR YOUR UNDERSTANDING!

Patient Signature

If a minor, Parent or Guardian Signature

Date: _____



Oral Abnormalities Screening

This practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral abnormalities and its relationship with serious oral diseases such as oral cancer and screen for it in every patient.

Oral cancer is one of the deadliest with research showing that late detection of oral cancer as the primary reason that mortality rates are so dismal. 'As with most other cancers, age is a primary risk factor for oral cancer. Tobacco use is also a major predisposing risk factor.'

We find that using VELScope Vx – Along with a visual examination. Early detection of abnormalities can minimize or eliminate the harmful and potentially disfiguring effects of serious oral diseases such as cancer and possibly save your life. A painless exam gives us a better chance to find any oral abnormalities you may have at an early stage. The exam will be offered to you annually.

Dental insurance may or may not cover the exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form to use to file this procedure with your medical insurance provider. The fee for this exam is \$35.

___ Yes, I would like to have this screening exam done at this time.

___ No, I would prefer not to have an oral abnormality screening Exam at this time.

Oral Cancer Risks Include:

- Tobacco Use
- Chronic Alcohol Consumption
- Oral HP 16/18 Infection

25% of Oral Cancer Occur in people who smoke and have no other risk factors.

Print Name: _____

Signature: _____

Date: _____