Welcome! *So that we may provide you with the best possible care, please complete the enclosed Registration and Medical/Dental History forms. All information is completely confidential.*

Patient Information

Patient Name _____ How do you wish to be addressed? _____
FIRST INITIAL LAST

Address _____ City _____ State _____ Zip Code _____

Employer _____ E-Mail _____

Home Telephone _____ Business Telephone _____ Date of Birth _____

Social Security _____ ❑ Female ❑ Male ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Other

In case of emergency, contact _____ Telephone _____

Whom may we thank for this referral? _____

Account Information

Person responsible for account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip Code _____

Home Telephone _____ Business Telephone _____ ext. _____

Date of Birth _____ ❑ Female ❑ Male Social Security _____

Services will be paid by ❑ Cash at each appointment ❑ Check ❑ Credit Card ❑ Other

Insurance Information

Primary Carrier

Subscriber _____ Date of Birth _____ Social Security No. _____

Employer _____ Address _____ Telephone _____

Insurance Co. _____ Address _____ Telephone _____

Group Number _____ Policy Number _____ Relationship to Patient _____

Secondary Carrier

Subscriber _____ Date of Birth _____ Social Security No. _____

Employer _____ Address _____ Telephone _____

Insurance Co. _____ Address _____ Telephone _____

Group Number _____ Policy Number _____ Relationship to Patient _____

Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims of insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I authorize payment of insurance benefits directly to the dentist.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.
Payment for dental services provided in this office for myself and my dependents is due and payable at the time services are rendered unless financial arrangements have been made. I understand that a 1-1/2% finance charge (18% annual percentage rate) on unpaid balance over 90 days will be added to my account.
I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature _____ Date _____

ACQUAINTANCE FORM

Dental Associates, P.A. 2205 S. Solano Drive Las Cruces, New Mexico (575) 522-7320

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulpha		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6.	Have you had any teeth removed?	☐	☐
SMILE CHARACTERISTICS			
7.	Is there anything about the appearance of your teeth that you would like to change?	☐	☐
8.	Have you ever whitened (bleached) your teeth?	☐	☐
9.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
10	Have you been disappointed with the appearance of previous dental work?	☐	☐
BITE AND JAW JOINT			
11.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
12.	Do you / would you have any problems chewing gum?	☐	☐
13.	Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods?	☐	☐
14.	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
15.	Are your teeth crowding or developing spaces?	☐	☐
16.	Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
17.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
18.	Do you clench your teeth in the daytime or make them sore?	☐	☐
19.	Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
20.	Do you wear or have you ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE			
21.	Have you had any cavities within the past 3 years?	☐	☐
22.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
23.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
24.	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
25.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
26.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
27.	Do you get food caught between any teeth?	☐	☐
GUM AND BONE			
28.	Do your gums bleed when brushing or flossing?	☐	☐
29.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
30.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
31.	Is there anyone with a history of periodontal disease in your family?	☐	☐
32.	Have you ever experienced gum recession?	☐	☐
33.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
34.	Have you experienced a burning sensation in your mouth?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Dental Associates, PA
2205 South Solano Drive
Las Cruces, NM 88001
Office (575)522-7320
Fax (575)522-6395

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Dental Associates, PA may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Dental Associates, PA has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Dental Associates, PA will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Dental Associates, PA to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Dental Associates, PA has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Dental Associates, PA, 2205 South Solano Dr., Las Cruces, NM 88001.

FORM Us

Dental Associates, PA
Financial Policy

Dental Insurance

I understand that my dental insurance is a contract between the insurance carrier and me and NOT between the insurance carrier and the dentist. Therefore, ***I am responsible for all dental fees.*** *We will happily file claims for you, however you are responsible for your deductible and co-pay at the time services are rendered. We will do our best to estimate these fees for you based on the information that has been provided by your insurance company but it's* ***always*** *necessary for you to be aware of your own benefits. It is recommended that any treatment over $300.00 be preauthorized by your dental insurance company. However, it is not a guarantee of payment.*

Payment Policy

I am aware that in an effort to keep costs as low as possible, while maintaining a high level of professional care, the payment policy is as follows:

In the event insurance does not pay the amount estimated it is my responsibility to pay the balance within 60 days of treatment.

If I do not have dental insurance, *I will be responsible for payment at the time of treatment unless arrangements are made prior to the treatment date. Please inquire about payment options prior to treatment.*

Service Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month applied to the last month's balance. In case of default of payment, I promise to pay legal interest on balance, collection costs, and reasonable attorney fees incurred to cover collection of the outstanding account.

Broken Confirmed Appointments

I realize a $25.00 charge will be billed to my account if I fail to show for my confirmed appointment.

Signature of Responsible party/patient *Date*