ACQUAINTENCE FORM

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? ______________

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 Alabama Zip Code ______________

Employer ______________ Occupation ______________

Business Address ______________ City ______________ State Alabama 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

Carrier 1

Subscriber ______________ Date of Birth ______________ Social Security ______________

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 payer 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, Parent or Guardian Signature ______________ Date ______________

MEDICAL HISTORY

Patient Name ______________________ Nickname ____________ Age ____ Who referred you ________________

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

1. hospitalization for illness or injury ◯Yes ◯No
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 ◯Yes ◯No
4. history of infective endocarditis ◯Yes ◯No
5. artificial heart valve, repaired heart defect (PFO) ◯Yes ◯No
6. pacemaker or implantable defibrillator ◯Yes ◯No
7. artificial prosthesis (heart valve or joints) ◯Yes ◯No
8. rheumatic or scarlet fever ◯Yes ◯No
9. high or low blood pressure ◯Yes ◯No
10. a stroke (taking blood thinners) ◯Yes ◯No
11. anemia or other blood disorder ◯Yes ◯No
12. prolonged bleeding due to a slight cut (INR > 3.5) ◯Yes ◯No
13. emphysema, sarcoidosis ◯Yes ◯No
14. tuberculosis ◯Yes ◯No
15. asthma ◯Yes ◯No
16. breathing or sleep problems (i.e. snoring, sinus) ◯Yes ◯No
17. kidney disease ◯Yes ◯No
18. liver disease ◯Yes ◯No
19. jaundice ◯Yes ◯No
20. thyroid, parathyroid disease, or calcium deficiency ◯Yes ◯No
21. hormone deficiency ◯Yes ◯No
22. high cholesterol or taking statin drugs ◯Yes ◯No
23. diabetes (HbAlc = _______) ◯Yes ◯No
24. stomach or duodenal ulcer ◯Yes ◯No
25. digestive disorders (i.e. gastric reflux) ◯Yes ◯No
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ◯Yes ◯No
27. arthritis ◯Yes ◯No
28. glaucoma ◯Yes ◯No
29. contact lenses ◯Yes ◯No
30. head or neck injuries ◯Yes ◯No
31. epilepsy, convulsions (seizures) ◯Yes ◯No
32. neurologic problems (attention deficit disorder) ◯Yes ◯No
33. viral infections and cold sores ◯Yes ◯No
34. any lumps or swelling in the mouth ◯Yes ◯No
35. hives, skin rash, hay fever ◯Yes ◯No
36. venereal disease ◯Yes ◯No
37. hepatitis (type ________) ◯Yes ◯No
38. HIV/AIDS ◯Yes ◯No
39. tumor, abnormal growth ◯Yes ◯No
40. radiation therapy ◯Yes ◯No
41. chemotherapy ◯Yes ◯No
42. emotional problems ◯Yes ◯No
43. psychiatric treatment ◯Yes ◯No
44. antidepressant medication ◯Yes ◯No
45. alcohol/ drug dependency ◯Yes ◯No

ARE YOU

46. presently being treated for any other illness ◯Yes ◯No
47. aware of a change in your general health ◯Yes ◯No
48. taking medication for weight management (i.e. fen-phen) ◯Yes ◯No
49. taking dietary supplements ◯Yes ◯No
50. often exhausted or fatigued ◯Yes ◯No
51. subject to frequent headaches ◯Yes ◯No
52. a smoker or smoked previously ◯Yes ◯No
53. considered a touchy person ◯Yes ◯No
54. often unhappy or depressed ◯Yes ◯No
55. FEMALE - taking birth control pills ◯Yes ◯No
56. FEMALE - pregnant ◯Yes ◯No
57. MALE - prostate disorders ◯Yes ◯No

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 ______________________________

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:

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) ◯ Yes ◯ No
2. Have you had an unfavorable dental experience? ◯ Yes ◯ No
3. Have you ever had complications from past dental treatment? ◯ Yes ◯ No
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ◯ Yes ◯ No
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ◯ Yes ◯ No
6. Have you had any teeth removed? ◯ Yes ◯ No

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? ◯ Yes ◯ No
8. Have you ever whitened (bleached) your teeth? ◯ Yes ◯ No
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? ◯ Yes ◯ No
10. Have you been disappointed with the appearance of previous dental work? ◯ Yes ◯ No

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ◯ Yes ◯ No
12. Do you /would you have any problems chewing gum? ◯ Yes ◯ No
13. Do you/ would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? ◯ Yes ◯ No
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ◯ Yes ◯ No
15. Are your teeth crowding or developing spaces? ◯ Yes ◯ No
16. Do you have more than one bite and squeeze to make your teeth fit together? ◯ Yes ◯ No
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ◯ Yes ◯ No
18. Do you clench your teeth in the daytime or make them sore? ◯ Yes ◯ No
19. Do you have any problems with sleep or wake up with an awareness of your teeth? ◯ Yes ◯ No
20. Do you wear or have you ever worn a bite appliance? ◯ Yes ◯ No

TOOTH STRUCTURE

21. Have you had any cavities within the past3 years? ◯Yes ◯No
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ◯Yes ◯No
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ◯Yes ◯No
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ◯Yes ◯No
25. Do you have grooves or notches on your teeth near the gum line? ◯Yes ◯No
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ◯Yes ◯No
27. Do you get food caught between any teeth? ◯Yes ◯No

GUM AND BONE

28. Do your gums bleed when brushing or flossing? ◯Yes ◯No
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ◯Yes ◯No
30. Have you ever noticed an unpleasant taste or odor in your mouth? ◯Yes ◯No
31. Is there anyone with a history of periodontal disease in your family? ◯Yes ◯No
32. Have you ever experienced gum recession? ◯Yes ◯No
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ◯Yes ◯No
34. Have you experienced a burning sensation in your mouth? ◯Yes ◯No

Patient's Signature ______________________ Date ____________

Doctor's Signature ______________________ Date ____________

NOTICE OF PRIVACY PRACTICES

DENTAL ASSOCIATES PA
2205 S. Solano Dr.
575-522-7320 (p)
575-522-6395 (f)

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

Under the Health Insurance Portability & Accountability Act of 1996 (HIPP A), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPPA.

This notice of Privacy Practices is effective on **April 14, 2003**.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act.
• Treatment
• Payment
• Health care operations

We may, without prior consent use or disclose your personal health information to carry out treatment, payment or healthcare operations.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to revocation notice.

We may contact you to provide appointment reminders, or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you. We may also contact you for fund raising purposes.

Under HIPPA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction;
- You have the right to receive confidential communications of your protected health information, either directly from us or by alternative means or from alternative locations;
- You have the right to inspect and copy your protected health information;
- You have the right to amend protected health information, however, this request may be denied under certain circumstances;
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to date of the accounting request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically

If you feel your privacy rights or the provisions of this notice of privacy policies, has been violated, you have the right to file a formal written complaint. This complaint should be addressed either to the Privacy Officer at our office, or directly to the Department of Health Services, Office of Civil Rights. Both addresses appear below. You will not be retaliated against, in any way, for filing a complaint.

For information about HIPPA
Or to file a complaint, contact:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington, DC 20201

Privacy Officer
Eileen Ambriz
Dental Associates PA
2205 S. Solano Dr.
Las Cruces, NM 88001
575-522-7320

PATIENT CONSENT FORM

DENTAL ASSOCIATES PA
2205 S. Solano Dr.
575-522-7320 (p)
575-522-6395 (f)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information as disclosed in the Notice of Privacy Practices.

Signed this ______________ day of ______________________________ 20 ________________

Print Patient Name: ____

Relationship to Patient: ____

Signature: ____

FINANCIAL POLICY

DENTAL ASSOCIATES PA
2205 S. SOLANO DR.
575-522-7320 (P)
575-522-6395 (F)

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 copay 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, 25% of past due 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*

AUTHORIZATION OF RELEASE FORM

DENTAL ASSOCIATES PA
2205 S. SOLANO DR.
575-522-7320 (P)
575-522-6395 (F)

Name: ______________________ Date of Birth: ______________

Address: ______________________ Phone: ______________

____

I, ______________________ hereby give my consent to ______________________
(Patient First and Last Name) (Previous Provider Name)
to release all of my Dental Records, Panoramic X-Ray aged 5 years or less, FMX aged 5 years or less, Bitewing X-Rays age 2 years or less, ALL Pathology reports and any Referral Letters from Specialists to **DENTAL ASSOCIATES PA** for the myself and minor children listed:

Name: ______________________ Date of Birth: ______________

Name: ______________________ Date of Birth: ______________

Name: ______________________ Date of Birth: ______________

Name: ______________________ Date of Birth: ______________

Name: ______________________ Date of Birth: ______________

Please email all X-rays and ALL Patient Records to: appointment@da-lc.com

______________________ ______________
Patient, Parent or Guardian Signature Date

OFFICE USE ONLY

Date Faxed: ______________

Date Received: ______________

Employee Initials: ______________