ALONSO
FAMILY DENTAL

MEDICAL ALERT

PATIENT REGISTRATION AND MEDICAL/DENTAL HISTORY

So that we may provide you with the best possible care, please complete both side of this medical/dental history form.

Pharmacy _____
Phone _____

Date _____
Home Phone _____ Work Phone _____ Cell/Pager _____ Email _____
Patient Name _____
Address _____
City _____ State _____ Zip Code _____ Social Security # _____ Driver's License # _____
Sex: ❑ Male ❑ Female Age _____ Birthday ___/___/___ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Employed By _____
Occupation _____
Business Address _____
City _____State _____ Zip Code _____ Tel. _____
Spouse Name _____ Birthday ____/____/____
Employed By _____
Business Address _____
City _____State _____ Zip Code _____ Tel. _____

Person Responsible for Account
Name _____ Relation _____
Billing Address _____
_____
Hm # ( ) _____DL # _____
Employer _____
Work Phone _____
Hm # ( ) _____Ext:____SS # _____

Dental Insurance Primary Carrier

Insured's Name _____ Social Security # _____
Insurance Company _____ Telephone _____
Address _____
City _____ State _____ Zip _____
Group Number _____ ID Number _____ Birth date _____
Birth date _____
Insured's Employer _____

Dental Insurance Secondary Carrier

Insured's Name _____ Social Security # _____
Insurance Company _____ Telephone _____
Address _____
City _____ State _____ Zip _____
Group Number _____ ID Number _____ Birth date _____
Birth date _____
Insured's Employer _____

In case of emergency, who should be notified? _____ Tel. _____
Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____
Address _____ Telephone _____

PLEASE CHECK THE BOX OF ANY CONDITION YOU MAY HAVE HAD.

- ❑ AIDS/HIV positive or other
- ❑ Allergies to anesthetics
- ❑ Allergy to colored dyes
- ❑ Allergy to Latex
- ❑ Angina pectoris
- ❑ Arthritis/rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joints
- ❑ Aspirin taken daily
- ❑ Asthma
- ❑ Back problems
- ❑ Blood disease
- ❑ Blood transfusion
- ❑ Cancer, leukemia
- ❑ Chemical dependency
- ❑ Chemotherapy/radiation therapy
- ❑ Chronic diarrhea
- ❑ Circulatory problems
- ❑ Contact lenses
- ❑ Diabetes
- ❑ Epilepsy/seizures
- ❑ General allergies* (list below)
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart disease or attack
- ❑ Heart murmur
- ❑ Heart pacemaker
- ❑ Hemophilia
- ❑ Hepatitis, jaundice or liver disease
- ❑ High blood pressure
- ❑ Hypoglycemia
- ❑ Kidney problem
- ❑ Low blood pressure
- ❑ Mitral valve prolapse
- ❑ Nervous problems
- ❑ Premedicate
- ❑ Psychiatric care
- ❑ Recent weight loss
- ❑ Respiratory problem
- ❑ Rheumatic fever
- ❑ Sinus problems
- ❑ Special diet
- ❑ Stroke
- ❑ Swollen neck glands
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal disease
- ❑ Other* (list below)

* General Allergies _____
* Other _____

DENTAL HISTORY

Patient Name

What is the reason for your visit today? _____

Is there anything about having dental treatment that you would like us to know? ❑ Yes ❑ No

If yes, please describe _____

_____

Date of last: **Dental Visit** _____ **Dental Cleaning** _____ **Full Mouth X-ray** _____ **Bitewing X-ray** _____

What treatment was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____

City _____ State _____ Zip Code _____

How often do you have dental examinations? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? ❑ Yes ❑ No If yes, please describe _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
(pencils, pipes, pins, nails, fingernails)	Yes	No
Hold foreign objects with your teeth?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco? How much? .	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If yes, please describe, including cause: _____

_____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweet?	Yes	No
Biting or chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experiences gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or a change in your bite?	Yes	No
Do you have difficulty in chewing on either side of the mouth?	Yes	No
Does food tend to become caught in between your teeth? If yes, where? _____	Yes	No

_____

Have you ever experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing your mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (necks, shoulders)?	Yes	No
Are you happy with your smile?	Yes	No
Are you pleased with the color of your teeth?	Yes	No
Would you like to keep all of your teeth?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
If yes, what is your biggest concern? _____	Yes	No

_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe: _____

_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? ❑ Yes ❑ No

If yes, list _____

Have you ever responded adversely to medical or dental treatment? ❑ Yes ❑ No

Have you ever been advised to be pre-medicated prior to any dental treatment? ❑ Yes ❑ No

Are you taking any medication at this time? ❑ Yes ❑ No If yes, what? _____

Have you ever taken Phen-Fen? Or Redux? ❑ Yes ❑ No If so, have you ever seen a cardiologist for a consult since taking it? ❑ Yes ❑ No

Are you under the care of a physician? ❑ Yes ❑ No If yes, for what condition? _____

If patient is a child, what is his/her weight? _____

Have you had a recent transfusion? ❑ Yes ❑ No

Is there anything else we should know about your medical history? _____

Women – Are you pregnant? ❑ Yes ❑ No

Nursing? ❑ Yes ❑ No

Taking birth control pills? ❑ Yes ❑ No

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. _____

Staff/Dr.'s Initials Date

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits which I am entitled. 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 payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the 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 behalf of my dependents.

Signature of Patient or Parent of Minor _____ Date _____

ALONSO
FAMILY DENTAL

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ALONSO FAMILY DENTAL FINANCIAL POLICY

This is an agreement between Dr. Alonso's dental practice, and the Patient/Debtor named on this form.

In this agreement, the words "you," "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we" and "us" refer to Dr. Alonso Family Dental.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, and new charges to the account, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten (10) days.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of services.

Payment Options (if you have NO insurance)

Payment options - if you have NO insurance:

A. You choose to pay by ___ cash, ___ check, or ___ credit card on the day that treatment is rendered.
B. On treatment involving laboratory fees (crown, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and balance on completion or delivery date.
C. On extensive treatment, you may prefer to secure a bank, credit union or other third-party financing for the entire amount and make payments to the lending institution.
D. We offer special financing through outside financing.

Payment Options (if you have insurance)

Payment options - if you have insurance:

Your dental benefit program is a contract between you, your employer and the insurance company. As a courtesy to you, we will file your claims for you. You are responsible to us for any amount the insurance does not cover.

A. You choose to pay your deductible and any out-of-pocket portions at the time services are rendered by ___ cash, ___ check, or ___ credit card.
B. You choose to pay all of your treatment by ___ cash, ___ check, or ___ credit card. We will request your insurance carrier send their payment directly to you.
C. On extensive treatment (crown or bridges) you may choose to pay 50% of your out-of-pocket portion on the start or preparation date, and the balance on the completion or delivery date. (Normally three weeks later).

Rebilling Fee: A rebilling fee of $15 will be imposed on each account that is over thirty (30) days past due.

Missed Appointment Fee: If you do not make it on time for an appointment or cancel with less that 48 hours notice, there will be a missed appointment fee. The charge is $25 for a Maintenance/Re-Evaluation Appointment, and 10% of the total fee for dental work appointments.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections costs which are incurred.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parents responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parents.

Transferring Your Records: You will need to request in writing and pay a reasonable copying fee of $15 if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization with us, you authorize us to receive all relevant information.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein will be in full force and effect.

Patient's Name: _____

Responsible Party (if not the patient): _____

Signature: _____ Date: _____