Hermosa Dental
DENTISTRY AND ORTHODONTICS

.

Patient's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ **Home phone** _____ **Cell phone** _____

Mailing address _____Unit_____ City _____State _____ Zip _____

email _____Employer _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

Whom may we thank for referring you to our office? _____

Emergency contact:_____ **Phone:**_____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco?❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills

- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Bone Medication:_____
- ❑ Other:_____
  _____

Women:

- ❑ May be pregnant

Expected delivery date: _____

- ❑ Taking hormones or contraceptives

Name of your physician_____

Do you have any disease, condition, or problem not listed above?_____

_____

Have you in the past taken any medications for your bones or Osteoporosis?

_____

Please add anything else you would like us to know

about:_____

_____

Please List all Medications that you are currently taking

Signature of patient (or parent) _____ Date _____

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Dental Financial Policy and Agreement

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

Payment

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options:

Cash, Checks, Visa, MasterCard, Discover, and American Express

Pre-payment Discounts

Monthly payment plans in accordance with the office credit guidelines

CareCredit payment options (6, 12, and 18 no interest plans or 24 to 60 extended 14.9% interest

Plans)

Insurance

Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf. If you have any questions our knowledgeable and courteous staff is always available to answer them.

Service Charges

There will be a 25 fee for returned checks.

Collections Fees

Fees incurred to collect payment will be billed to and payable by the patient's account holder

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this financial Policy and Agreement

_____ _____

Signature of patient/responsible party Date

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Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change and appointment, please give us at least a 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a $25 charge for not showing up for your scheduled appointment. Repeated cancellations or missed appoint will result in loss of future appointment privileges

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Signature_____ Date____/_____/____

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Nombre _____Apellido _____Fecha de Nacimento_____

Nombre de padres si paciente es menor _____ Telefono _____ Cellular _____

Domicilio _____ #de Apa._____ Ciudad_____Estado_____ Codigo postal_____

email _____ Empleador _____ Seguro social: _____

Nombre de Esposo/Esposa _____ Telefono de Esposo/Esposa_____

Contacto de Emergencia_____ Telefono de Contacto De Empergencia

A quien podemos agradecer por referirlo a nuestra oficina? _____

INFORMACION DE ASEGURANZA: ❑ No tengo aseguranza

Nombre de aseguranza._____ numero del grupo_____ Seguro social: _____ Empleador_____

Esta cubierto con la aseguranza de su esposo/esposa ? ❑ si ❑ no

Aseguranza de su esposo /esposa _____ numero del grupo _____

Fecha de Nacimento de esposo/esposa _____ Seguro Social _____Empleador _____

Motivo de su consulta de hoy:(scleccione con un circulo) Exmen/Limpieza Dolor/Inflamacion Diente Roto/caries

Fecha de ultimo examen dental:_____ Ultima limpieza_____

HISTORIAL MEDICO

Tiene uno de lo siguente?
(por favor marque lo que aplica)

Esta en buena salud general? ❑si ❑no

- ❑ Cancer o tumores
- ❑ Infarto de Corazon /defectos en el corazon
- ❑ Valvula artificial del Corazon/Enfermedades del Corazon
- ❑ Fiebre reumatica/ Soplos en el Corazon
- ❑ Valvulas artificiales/empalmes artificales
- ❑ Alta presion/baja presion
- ❑ Marcapasos
- ❑ Tuberculosis
- ❑ Enfermedades renales(rinon) vejiga
- ❑ Hepatitis/otras enfermedades del higado
- ❑ Alcoholismo
- ❑ Tranfusion de sangre
- ❑ Diabetes
- ❑ Epilepsia/convulsiones/mareos
- ❑ Enfermedades de tiroides o glandulas
- ❑ Artritis/reumas
- ❑ Herpes/Enfermedades venereas
- ❑ HIV/SIDA
- ❑ Migrañas/Desmayos
- ❑ Anemia/problemas de sangrado/moretes
- ❑ Sangrado abnormal/Trastornos en el sangrado y la coagulacion
- ❑ Colesterol
- ❑ Depresion
- ❑ Asma

Tabaco de cualquier tipo? ❑si ❑ no

Esta alergico o a tenido racion alerica a lo siguente?

- ❑ Latex
- ❑ Penecillina o otra antibotico
- ❑ Anesthia local ("Novocain")
- ❑ Codeine or otro narcoticos
- ❑ Medicina con sulfa
- ❑ Asperina
- ❑ otro:_____

Esta tomado los siguentes medicamentos?

- ❑ Asperina
- ❑ Anticoagulantes (para a delgazar la sangre)
- ❑ Antibioticos or medicina con sulfa
- ❑ Medicamento para Alta Presion
- ❑ Antidepressantes o tranquilizantes
- ❑ Insulina o otra medicina para el diabetes
- ❑ Nitroglycerin
- ❑ Cortisone o otro esteroids
- ❑ Medicina para Osteoporosis (densida para los huezos)
- ❑ Medicamento para huezos_____
- ❑ Otro:_____
  _____

Mujers:

- ❑ Puedo estar o Estoy embarazada
  Fecha de parto: _____
- ❑ Estoy tomando hormonas

Nombre de su doctor primario:_____ Telefono de doctor primario_____

Tiene una condicion medica no mencionada en el historial medico?_____

_____

En el pasado ha tomado medicina para los huesoso osteoporosis?_____

_____

Por favor agregue otra cosa que quiera decirnos referente a sus experiencias dentales previas:_____

_____

Por favor haga una lista de cualquier medicamento que este tomando

Firma del Paciente (o Pardes) _____ Fecha_____