VARGAS
DENTAL ASSOCIATES

PATIENT DEMOGRAPHICS/CLINICAL INFORMATION

Please take a few minutes to answer the following questions, so we can better assist your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthday _____

Name _____ Home phone _____
Last Name First Name Initials

Address _____ Cell phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐M ☐F ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initials

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance (if applicable)

Insured Name _____
Last Name First Name Initials

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please Complete Reverse Side →

Dental History

Former Dentist _____
City, State _____
Date of Last Dental Visit _____
Date of Last X-Rays _____
How Often Do You Floss? _____
How Often Do You Brush? _____

Please check all that apply

Bad Breath ☐	Loose Teeth or Broken Fillings ☐	Sensitivity to Sweets ☐
Bleeding Gums ☐	Orthodontic Treatment ☐	Sensitivity When Biting ☐
Blister on Lips or Mouth ☐	Pain Around Ear ☐	Frequent Headaches ☐
Finger Nail Biting ☐	Periodontal Treatment ☐	Jaw, Head or Neck Injuries ☐
Grinding Teeth ☐	Sensitivity to Cold ☐	Jaw Difficulties: Clicking and/or Pain ☐
Lip or Check Biting ☐	Sensitivity to Heat ☐	Tooth Pain ☐

Medical History

Physician's name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication? Please list them with dosage: _____	☐	☐
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reaction to the following:

	Yes	No
Local Anesthetics (eg. Novocaine)	☐	☐
Penicilin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are you:

Pregnant?	☐	☐
Nursing?	☐	☐

Please check all that apply:

AIDS ☐	Epilepsy ☐	Nervous Problems ☐
Abnormal Bleeding ☐	Fainting or Dizziness ☐	Pacemaker ☐
Anemia ☐	Glaucoma ☐	Psychiatric Care ☐
Arthritis, Rheumatism ☐	Headaches ☐	Radiation Treatment ☐
Artificial Heart Valves ☐	Heart Murmur ☐	Respiratory Disease ☐
Artificial Joints ☐	Heart Problems ☐	Rheumatic Fever ☐
Asthma ☐	Hepatitis-Type ☐	Scarlet Fever ☐
Back Problems ☐	Herpes ☐	Shortness of Breath ☐
Blood Disease ☐	High Blood Pressure ☐	Sinus Trouble ☐
Cancer ☐	High Cholesterol ☐	Skin rash ☐
Chemical Dependency ☐	HIV Positive ☐	Stroke ☐
Chemotherapy ☐	Jaundice ☐	Swelling of Feet/Ankles ☐
Chronic Fatigue Syndrome ☐	Jaw Pain ☐	Swollen Neck Glands ☐
Circulatory Problems ☐	Kidney Disease ☐	Thyroid Problems ☐
Congenital Heart Lesions ☐	Latex Sensitive ☐	Tonsillitis ☐
Cortisone Treatment ☐	Liver Disease ☐	Tuberculosis ☐
Cough – persistent or bloody ☐	Low Blood Pressure ☐	Tumor or growth on head/neck ☐
Diabetes ☐	Mental Disorders ☐	Ulcer ☐
Emphysema ☐	Mitral Valve Prolapse ☐	Venereal Disease ☐

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered on my behalf or my dependants.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

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NOTICE OF PRIVACY PRACTICES

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.

The Health Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected information, including those related to disclosures to family members, other relatives, close personnel friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices*. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: ___/___/____ Initials: _____

Reason:

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PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ D.O.B: _____

Address: _____

Option 1

I hereby authorize the disclosure and use of my health information and financial information (check as appropriate) to:

Name	*Address*
_____	_____
_____	_____
_____	_____
_____	_____

I authorize the disclosure of the following information:

Financial ..... ☐

Appointments ..... ☐

Treatment ..... ☐

Other ..... ☐

Option 2

_____ I do not want any information released to anyone.

I understand that I have the right to revoke this authorization at any time. If I wish to do so, I must do it in writing and it will be effective immediately.

Patient Signature: _____ Date: _____

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OFFICE POLICIES

We are pleased that you have selected us to provide you and your family with dental care. To ensure our ability to provide you with the best service, please adhere to the following office policies.

Payment of Fees:

Payment is due when services are rendered. In some cases, a treatment plan may exceed your Insurance Carrier's coverage limit. To help make dental services more affordable, our practice offers an easy to use finance plan through CareCredit. An18% APR or a minimum of $10.00 finance charge is automatically applied to accounts 60 days or older on a monthly basis. In the event that collection procedures are instituted hereon, I agree to pay all expenses of collection, including court costs and a reasonable attorney fee, if such is incurred.

Insurance:

I understand that I am financially responsible for all charges whether or not they are covered by insurance. I also understand that all co-pays quoted are an estimate and not a guarantee of payment or coverage by any insurance company. I understand that it is my responsibility to know my insurance policy.

Broken and Cancelled Appointments:

Broken appointments are a disappointment for everyone. They interfere with dental treatment and create unnecessary scheduling problems for other patients, as well as the office. We attempt to schedule appointments that are the most convenient for you, and fit your personal schedule. Because we do not overbook our patients, we ask that you make every effort not to change your reserved dental appointment. If you find that you cannot keep your scheduled appointment we request 48-hour notice in order to avoid a broken appointment fee. The broken appointment fee is $60.00.

PLEASE DO NOT rely on our reminder calls or text messages! They are strictly courtesy calls. Please remember to keep your phone numbers and email addresses updated with us.

Tardiness:

Our office strives to see all our patients at their appointed times. If you are more than 15 minutes late to your appointment, it may not be possible to see you. You may be asked to reschedule for another appointment. If you think you are going to be late, please call us immediately.

Transfer Record Fee:

There will be a transfer record charge of $35.00 if requesting x-rays or records. You will also need to sign a record release form.

Returned/Bounced Checks:

Any checks returned for insufficient funds will be charged back to the account. A returned check fee of $35.00 will be added to the balance. You are required to pay the amount of the returned check and the additional fee by cash, *IMMEDIATELY*.

Patient Name:_____

I hereby certify that I have read the foregoing disclosure statement on _____ and agree to the terms thereof.

Printed Name of Responsible Party _____ Signature of Responsible Party _____