WELCOME

Date _____

First Name _____ Last Name _____ Middle Initial _____

Preferred Name _____ Birthday _____ Age _____ ( )Male ( )Female

SS# _____ ( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced ( ) Child

Address _____ City _____ State _____ Zip _____

Home Phone (____)_____ Cell (____)_____ Work (____)_____Ext _____

Email _____ Occupation _____ Employer _____

Who is responsible for this account? _____ Relationship_____

In case of emergency, who should be notified? _____ Phone (____)_____

Whom may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Insurance Co. Name _____ Phone (____)_____ Group # _____

Subscriber Name _____ SS-ID# _____ Birthday _____

Relationship to Pt. _____ Insured's Employer _____

I certify that I and/or my dependent(s), have insurance coverage, and assign directly to Drs. Quevedo all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered or paid by my insurance. I authorize the use of my signature on all insurance submissions.

_____

Patient Signature

DENTAL HISTORY

Reason for today's visit _____

Date of last dental visit _____ Date of last dental x-rays _____

Are you in dental discomfort today? ( ) Yes ( ) No Do you grind your teeth? ( ) Yes ( ) No

Do your gums bleed when you brush or floss? ( ) Yes ( ) No

Are your teeth sensitive to: ( ) Hot ( ) Cold ( ) Sweets ( ) Pressure

Is there anything you would like us to know about your dental health or previous dental treatment?

_____

_____

MEDICAL HISTORY INFORMATION

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Physician _____ Phone (____)_____

Do you have or have ever had any of the following? Please check those that apply:

( ) AIDS/HIV Positive	( ) Glaucoma	( ) Mitral Valve Prolapse
( ) Alzheimer's Disease	( ) Heart Attack	( ) Pain in Jaw Joints
( ) Anemia	( ) Heart Murmur	( ) Psychiatric Care
( ) Angina	( ) Heart Pace Maker	( ) Radiation Treatments
( ) Arthritis	( ) Heart Disease	( ) Recent Weight Loss
( ) Artificial Joints	( ) Hemophilia	( ) Renal Dialysis
( ) Artificial Heart Valves	( ) Hepatitis A	( ) Rheumatic Fever
( ) Asthma	( ) Hepatitis B or C	( ) Shingles
( ) Cancer/Chemotherapy	( ) Herpes	( ) Sickle Cell Disease
( ) Cholesterol	( ) High Blood Pressure	( ) Sinus Trouble
( ) Cold Sores/Fever Blister	( ) Hypoglycemia	( ) Intestinal Disease
( ) Congenital Heart Disorder	( ) Irregular Heartbeat	( ) Stroke
( ) Diabetes	( ) Kidney Problems	( ) Thyroid Disease
( ) Drug Addiction	( ) Leukemia	( ) Tuberculosis
( ) Emphysema	( ) Liver Disease	( ) Tumors or Growths
( ) Epilepsy or Seizures	( ) Low Blood Pressure	( ) Ulcers
( ) Excessive Bleeding	( ) Lung Disease	( ) Venereal Disease

Do you have any health problems that were not listed above? _____

_____

Are you allergic to any medications or substances? If yes, please check box below:

( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Acrylic ( ) Metal ( ) Latex ( ) Anesthetics

( ) Other If yes, please explain _____

Are you taking any medication at this time? Please list _____

Have you ever responded adversely to medical or dental treatment? _____

WOMEN Are you: ( ) Pregnant/Trying to get Pregnant ( ) Nursing ( ) Taking Oral Contraceptives

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Patient Signature Date

Welcome,

We are pleased that you have chosen our practice. Our commitment is to do our very best to serve your dental needs, whatever they may be, in a friendly and comfortable environment.

After careful evaluation, the dentist and hygienist will make treatment recommendations based upon what is best for each individual patient.

Please do not ask your doctor to provide only the covered benefits and neglect treatment, which is in the best interest of your own health.

We will do our best to inform you of your fees before any work is performed. In addition, we ask that you help control our cost by handling any non-covered insurance expense on the day services are begun. Our office offers several payment options for dental procedures, including financing. **All fees are to be paid in full when treatment is begun and prior to delivery or permanent cementation of any dental work.**

We ask that you turn your cell phones off while in our office.
Please be aware children are not allowed to wait in the operatory. It is a Florida statute.
We do have movies available to watch in our waiting room. Inquire at the front desk.

Please sign below acknowledging that you understand and agree with our policies and commitment to you.

Thank you,

Fernando F. Quevedo, D. D. S., M. P. H.
Rachel M. Quevedo, D.D.S., M. P. H.

Notice of privacy practices acknowledgment
I understand the Health Insurance Portability & Accountability Act of 1996(HIPPA).
I have certain rights to privacy regarding my protected health information.
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 you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Sign here ----------

FINANCIAL ARRANGEMENTS AND OFFICE POLICIES

* Our office policy is that patients pay for services at the time of service.

* Payment can be made with **Cash, Check, MasterCard, Visa, Discover**
* There will be a $35.00 processing fee for any returned checks.

* **DENTAL INSURANCE IS ONLY AN ESTIMATE**
  Please note that dental insurance is a contract between you and your insurance carrier and therefore, you remain responsible to our office for all dental services. Insurance plans vary widely. We are committed to helping you optimize your insurance benefits. All benefits that we receive from your insurance carrier will be credited to your account, but keep in mind that insurance coverage is only ESTIMATED by our office at the time of treatment and you remain responsible for any difference between our quoted fees and what the insurance actually pays (including if your insurance carrier denies or does not pay a claim for ANY reason). You must pay the entire billed balance or you will be subject to finance or billing charges.

* **FINANCE OR BILLING CHARGES**
  If you do not pay the entire billed balance by the billing date, a finance charge will be added to your account. Accounts in default will also be subject to collection proceedings at our sole discretion.
  In the case of default of payment, you will be responsible for all legally permissible interest on the balance due to us, together with collection costs and reasonable attorney fees.

* **CANCELLATION POLICY**
  Appointment times are reserved especially for you. If you must change your appointment time, you must notify us at least **48** hours in advance. **All appointments cancelled without a 48 hour notice will be subject to a charge.**

By signing below I acknowledge that I have read and agree to the office policies described above.

_____

Signature Date