Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us- we will be happy to help.

Patient information/Información del paciente

Today's date/Fecha____________________

Full Name/Nombre	Birthdate/Fecha de nacimiento	Sex/Sexo	Address/ Dirección	City/Ciudad	State/ Estado	Zip/ código postal
		☐M ☐F ☐Other				

SS #/ID #	Cell Phone/Teléfono celular	Home Phone/Teléfono de casa	Emergency contact/Contacto de emergencia
			Name/Nombre Phone/Teléfono

E-mail/Correo E.	Check appropriate box/Escoja el appropiado	Race/Raza	Ethnicity/Etnicidad
	☐ Minor/Menor de edad ☐ Single/Soltero(a) ☐ Married/Casado(a) ☐ Widowed/Viudo(a) ☐ Divorced/Divorciado(a) ☐ Other/Otro		

Employer/School Empleador / Escuela	Phone# of Employer / School Teléfono del Empleador/ Escuela	Address of Employer/School Dirección del Empleador / Escuela	City/Ciudad	State/ Estado	Zip/ código postal

Preferred language/ Idioma preferido	Whom may we thank for referring you?/¿Referido por?

Dental history/ Historia dental

Reason for today's visit/ Motivo de la visita de hoy	Date of last dental care/ Fecha del último cuidado dental	Date of last dental X-rays/ Fecha de la última radiografía dental	Former dentist/ Anterior dentista

Former Dentist Address/Dirección de Dentista Anterior	How often do you floss and brush?/ ¿Con qué frecuencia usa hilo dental y cepillo

Check appropriate box if you have had problems with any of followings / Marque la casilla correspondiente si ha tenido problemas con alguno de los siguientes

☐ Bad Breath/ Mal aliento	☐ Bleeding gums/ Sangrado de las encias	☐ Sensitivity to hot/ Sensibilidad al calor
☐ Grinding teeth/ Moliendo de dientes	☐ Clicking or popping jaw/ Chasquido o chasquido de la mandíbula	☐ Sensitivity when biting/ Sensibilidad al morder
☐ Loose teeth / Dientes sueltos	☐ Sensitivity to cold/ Sensibilidad al frio	☐ Snores/ Ronca

Consent for Treatment

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize Comfort Dental Care PLLC to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risks.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

Responsibility for Payment: In the event that this matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection sums due and unpaid for the work herein set forth.

Notice of Privacy Practices (HIPAA)

A laminated copy of our office Notice of Privacy Practices (HIPAA) is available in our office. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations. Of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. Upon your request we will be happy to provide you with your own personal copy of our Privacy Practices.

Children or Minors

Because (name of child)______________________________is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their dental treatment.

Please print name/Escriba el nombre:____
of Patient, Parent, Guardian/ De Paciente, Padre, Guardián

Date/Fecha:______________________________**Signature/Firma:**______________________________________
of Patient, Parent, Guardian

DENTAL HISTORY

Reason for today's visit ______________________ Date of last dental care ______________________

Former Dentist ______________________ Date of last dental X-rays ______________________

Address ____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? ______________________ How often do you brush? ______________________

MEDICAL HISTORY

Physician's Name ______________________ Date of last visit ______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ______________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ______________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking and the correlating diagnosis:

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Allergies:

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AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr.______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

______________________ Signature of Patient, Parent, Guardian or Personal Representative ______________________ Date

______________________ Please print name of Patient, Parent, Guardian or Personal Representative ______________________ Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.