GARCIA MAYORAL DENTISTRY

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Referred By:

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Dental Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Dental Insurance

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

GARCIA MAYORAL DENTISTRY

Dr. Oliver Mayoral, DMD PA

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

GARCIA MAYORAL
DENTISTRY

DENTAL HISTORY

When was your last dental visit?_____

How often do you see your dentist?_____

Do any of the following cause tooth discomfort? Hot_____ Cold_____ Sweets_____ Chewing_____

How often do you brush your teeth?_____Floss?_____ Water Jet?_____

Do your gums bleed while you are cleaning? _____

Have you ever had a periodontal treatment?_____

Do you clench or grind your teeth?_____

Can you chew on both sides of your mouth?_____ Comfortably?_____

Do you have frequent headaches?_____

Have you ever had orthodontic treatment?_____ When? _____

Do you usually have many cavities?_____

Do you have loose teeth?_____ Cracked or broken teeth?_____

Do you have any missing teeth? _____ Have they been replaced?_____

If so, how? Dental implant_____ Fixed Bridge_____ Removable Partial_____Full denture_____

Are you comfortable with the replacement?_____ Please describe_____

Have you ever had cosmetic dentistry done to improve your appearance?_____

How do you feel about the appearance of your smile? Is there anything you would like to enhance, correct, or change with your smile?_____

Have you had an unpleasant dental experience?_____

How may we serve you to ensure you have the best possible experience while in our care?_____

Is there any disease , condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, please explain: _____

I understand that the preceding answers and information are true and correct to the best of my knowledge . I understand it will be held in the strictest confidence and only be used to improve communication between the doctor and myself. If I ever have any change in my health or change in my medication, I will inform the doctor at the next appointment. I certify that I have read and understand the Medical and Dental History forms. I will not hold the office of Garcia Mayoral Dentistry responsible for any errors or omissions that I may have made in the completion of this form.

I hereby grant permission to the doctor to administer such anesthetics and to perform such dental procedures as may be deemed nescesary or advisable in the treatment of this patient.

Signed:_____(Patient)/ (Responsible Party for this patient)

Date:_____ Relationship to patient:_____

HIPAA – PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

*HIPAA – CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with **GARCIA MAYORAL DENTISTRY., "**Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Confirmo que se me ha proveído con la "Nota De Practicas De Privacidad" de* **GARCIA MAYORAL DENTISTRY., *y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.*

Patient Name: *(please print)*

**Nombre Del Paciente: (nombre en letra de molde por favor)*

Patient Signature *(or legal representative; proof may be requested)*

**Firma Del Paciente: (o representante legal; prueba puede ser requerida)*

Date:

**Fecha:*

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM
*CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **GARCIA MAYORAL DENTISTRY., (GMD)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **GMD** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **GMD** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **GMD** and I, and consent to the conditions outlined herein. Any questions I may have had were answered.

***Propósito:** Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. **GARCIA MAYORAL DENTISTRY., (GMD)** ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **GMD** usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, **GMD** no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre **GMD** y yo, y consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente

My Consented Email Address is:

**Mi Correo Electrónico Consentido Es:*

My Consented Mobile Number For Text Messaging is:

**Mi Numero Móvil Para Mensaje De Texto Consentido Es:*

Patient Signature: **Date:**

Firma del Paciente* ****Fecha*

IN CASE OF EMERGENCY: *Please call 911 or proceed to the nearest emergency room.* ***Do not use this way of communication for that purpose.***
****EN CASO DE EMERGENCIA:*** *Por favor llame al 911 or proceda al centro de emergencia mas cercano.* ***No use esta forma de comunicación para este propósito.***

Rev.09/19

GARCIA MAYORAL

D E N T I S T R Y

FINANCIAL POLICY

We are proud to be part of a team whose primary mission is to provide the finest and most comprehensive dental care and service for all our patients. Good communication concerning dental problems, treatment procedures and fees is one of the most important goals. In order to minimize expense and maintain our practice's level of excellence, we request payment for services at the time they are rendered.

To assist you we provide the following payment options:

VISA, MASTERCARD, AMEX, CASH, PERSONAL CHECKS and financing with CARE CREDIT

THERE WILL BE A $50 CHARGE FOR RETURNED CHECKS.

FINANCIAL AGREEMENT

I understand that I am responsible for complete payment of professional fees for the services rendered at time of service. If legal action is necessary to settle this account, I AGREE TO PAY ALL COURT COSTS and ATTORNEYS FEES FOR COLLECTION.

If you have any concerns regarding our financial policy, please let us know.

PLEASE NOTE:

There are waiting period for some procedures with certain dental benefit plans. You MUST advise us of such waiting periods. Patient is fully financially responsible for any work completed during waiting periods. There are procedures which MAY NOT BE A COVERED procedure by your dental plan. You are responsible for our charges for these procedures in full.

I HAVE READ THE ABOVE POLICIES AND UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT FOR THE SERVICES PROVIDED TO ME BY DR. FAUSTINO G. GARCIA, DR. OLIVER MAYORAL, ASSOCIATES, AND/OR STAFF.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____ RELATIONSHIP TO PATIENT: _____
(Patient or responsible party for this account)

GARCIA MAYORAL DENTISTY

Faustino G. Garcia, DMD **Oliver Mayoral, DMD**

CANCELLATIONS/NO SHOW/LATE ARRIVAL POLICIES

We are pleased to provide you with personalized treatment and care.
Prescribed treatment schedules are important to ensure optimal progress.

As you know, your appointment requires that we reserve a significant amount of time *exclusively for you.* Cancellations and missed appointments necessitate a policy that is fair to both you and us, and to the many patients on our waiting list.

We do understand that everyone is subject to unexpected problems. In the event of circumstances beyond your control, that require you to cancel your appointment, there will be no charge for cancellations *made* **at least 24 hours prior to your scheduled appointment.** This will allow us to schedule other patients who are waiting for appointments. You can call, email or text your response.

Cancellation notices less than 24 hours in advance, regardless of the reason, or the failure to appear for the scheduled appointment, will result in you being charged $30.00 for the appointment fee. Unfortunately charges for missed appointments cannot be submitted to your insurance for reimbursement. Therefore, we encourage you to plan ahead to avoid any last-minute problems.

THANK YOU FOR YOUR ANTICIPATED UNDERSTANDING, COOPERATION, AND LOYALTY.

I have read and agree to comply with the above policy.

Signed: _____ (Patient)/ (Responsible Party for this patient)

Date: _____Relationship to Patient: _____