8500 S.W. 92nd Street, Suite 203
Miami, Florida 33156
305-271-5321

PATIENT REGISTRATION AND HISTORY

DATE:
Fecha: _____

PATIENT'S NAME: **BIRTHDATE:**
*Nombre del paciente:*_____ *Fecha de naciemento:*_____
GENDER **MARITAL STATUS:**
Genero Male _____ *Female* _____ *Estado Civil:*_____
NAME OF SPOUSE:
*Nombre del esposo(a):*_____
ADDRESS: **CITY:** **STATE:** **ZIP:**
*Direccion:*_____*Ciudad:*_____*Estado:*_____*Codigo Postal:*_____
HOME PHONE: **CELL PHONE:**
*Telefono de la casa:*_____*Telefono movil:*_____
EMAIL ADDRESS:
Direccion de correo electronico: _____
PREFERRED METHOD OF COMMUNICATION:
Metodo preferido de comunicacion: *Email* _____ *Phone* _____ *Text* _____
WHOM MAY WE THANK FOR REFERRING YOU?
Referidopor _____
PATIENT EMPLOYED BY: **WORK PHONE:**
Empleo del paciente: _____*Telefono del trabajo:*_____
PRESENT POSITION:
*Ocupacion:*_____
SPOUSE EMPLOYED BY: **WORK PHONE:**
*Empleo del esposo(a):*_____*Telefono del trabajo:*_____
PRESENT POSITION:
*Ocupacion:*_____
PERSON RESPONSIBLE FOR BILL:
*Persona responsable por la cuenta:*_____
SOCIAL SECURITY #: **DRIVERS LICENSE #**
*Numero del seguro social:*_____ **LICENCIA DE CONDUCIR #** _____

I authorize the release of medical information to process any of my insurance claims and I authorize payment of medical benefits directly to Maribel Lopez, DDS for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian or patient that in consideration of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

El (La) suscrito(a) autoriza que, toda la informacion medica necesaria para procesar cualquiera de mis reclamos a mi compania de seguros sea puesta a disposicion de esta. Asi mismo autorizo el pago de mis beneficios medicos directamente al Maribel Lopez, DDS. Entiendoy accepto que, independiente de mi condicion de asegurado(a), soy totalmente responsible de mi cuenta por los servicios profesionales recibidos en este centro. Si acaso esta cuenta fuese enviada a un servicio de cobranzas, todos los gastos que se originen de este recurso legal son tambien de mi responsabilidad y obligacion por cualquier balance pendiente que derive a causa cuentas legales y asumira costos de coleccion.

SIGNATURE: **DATE:**
Firma: _____ *Fecha:* _____

INSURANCE INFORMATION

Primary Insurance Information

Name of Insured | Insured Social Security Number | Insured Member ID

Relationship to Insured: Self Spouse Child Other

Insured Date of Birth _____

Employer | Address | City/St/Zip

Insurance Company | Address | City/St/Zip

Group/Plan# _____

Secondary Insurance Information

Name of Insured | Insured Social Security Number | Insured Member ID

Relationship to Insured: Self Spouse Child Other

Insured Date of Birth _____

Employer | Address | City/St/Zip

Insurance Company | Address | City/St/Zip

Group/Plan# _____

Patient Health Record

Patient Name Date of Birth

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

Are you under a physicians care now?	Yes	No	If yes, please explain: _____
Have you been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medication, pills or drugs?	Yes	No	If yes, please explain: _____
Do you take or have you taken Phen-Fen or Redux?	Yes	No	_____
Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonate	Yes	No	If yes, please explain _____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	
Do you use a controlled substance?	Yes	No	
Do you suffer from Sleep Apnea?	**Yes**	**No**	

Woman: Are You …

Pregnant/Trying to get pregnant? Yes No (if Yes how far along) ___ Taking Contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? Aspirin __ Penicillin __ Codeine __ Acrylic __ Metal __ Latex__ Local Anesthetics __ Sulfa __ Other __

If yes please explain reaction_____

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 Cholesterol	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Scarlet Fever	Yes	No
Artificial heart Valve	Yes	No	Excessive Bleeding	Yes	No	High Blood Pressure	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 or 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	Intestinal Disease/Stomach	Yes	No
Breathing Problem	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			Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Prolapse	Yes	No	Tuberculosis	Yes	No
Cold Sores/fever Blisters	Yes	No	Heart Murmur	Yes	No	Osteoporosis	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Pain in Jaw Joints	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Parathyroid Disease	Yes	No	Venereal Disease	Yes	No
Yellow Jaundice	Yes	No				Psychiatric Care	Yes	No			

Have you ever had any serious illness not listed above? Yes ___ No___ If yes explain:_____

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_____DATE_____

DENTAL HEALTH (CONT)

When was your last dental visit? _____

Have you ever had any serious problems associated with previous dental treatment?

Yes □ No □ If yes, explain: _____

How often do you brush your teeth? _____

How often do you floss? _____

Do you routinely use a mouth rinse? Yes _____ No _____

How often? _____

Do you experience dry mouth (Xerostomia)? Yes _____ No _____

What texture brush do you use? Soft ___ Medium ___ Hard ____

Do your gums feel tender or swollen? Yes _____ No _____

Do your gums bleed while brushing and/or flossing? Yes _____ No _____

Do you avoid brushing any part of your mouth because of pain or sensitivity? Yes _____ No _____

Do you feel your teeth are affecting your health in any way? Yes _____ No _____

Are any of your teeth sensitive to air or during chewing? Yes _____ No _____

Do you chew on only one side of your mouth? Yes _____ No _____

Does food catch between your teeth? Yes _____ No _____

Have you ever had professional advice in dental home care? Yes _____ No _____

Do you clench or grind your teeth while sleeping or during the day? Yes _____ No _____

Do you feel twinges of pain when your teeth come in contact with hot, cold, sweet or sour? Yes _____ No _____

Do your facial muscles ever feel tired?

Do you gag easily? Yes _____ No _____

Do you wear full dentures? Upper ____ Lower ____ Yes _____ No _____

Do you wear partial dentures? Upper ____ Lower ____

Do you have retention problems with your full or partial dentures?

Are you apprehensive (nervous) about your dental treatment? Yes _____ No _____

If yes — have you had: Nitrous Oxide ____ Medication prior to treatment ____ Yes _____ No _____

Please add anything you feel is important: _____

CONSENT:

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, study models, photographs, medications, or the use of local anesthetic agents. Any Insurance, including PPO's, will be filed as a courtesy and any charges not covered by insurance, is patient's responsibility, payment is expected at time of service. I agree that should this account be referred to an agency or attorney for collection I will be responsible for all collection cost attorney's fees and court costs.

PATIENT or GUARDIAN SIGNATURE DATE

Getting To Know You

If you could wave a magic wand and change one thing about your smile, what would it be?

_____

_____

If there were a simple, inexpensive way to whiten your teeth would you be interested?

YES _____ NO _____

If you needed to straighten your teeth, is this something you would be interested in?

YES _____NO _____

Why did you leave your last dentist?

_____

_____

What did you like best about your last dentist?

_____

_____

What did you like least about your last dentist?

_____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand, that under the Health Insurance and Accountability Act of 1996 ("HIPPA"), 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 health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 below 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 my treatment, payment, or health care operations. I also understand you are not required to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

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

Date:	**Initials:**	**Reason:**

Written Financial Policy

Welcome to our office and thank you for choosing Dentistry of Miami, the office of Dr. Randy Furshman and Associates for your dental care needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express, Discover Card, or Care Credit

Please note:

- In order to maintain the highest quality of dental treatment and care for our patients we ***require that all financial obligations must be taken care of prior to the completion of your treatment.***
- For patients with dental insurance we are happy to work with your carrier to maximize your benefit and ***provide you*** with the documentation you need to receive reimbursement for your treatment.
- A fee of $50 is charged for patients who miss more than 2 times in a calendar year without 48-hour notice.
- Personal checks are accepted as a method of payment at our office. Should your check **NOT** clear with our bank, ***a return check fee of $30 will be assessed on to your account.***
- Once establishing financial arrangements and should your account default with our office, ***any and all collection and attorney's fees will be the sole responsibility*** of the patient / responsible party, in addition to the outstanding balance.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)