Advanced
DENTAL CARE
Family & Cosmetic Dentistry
ELSA D. FLORES, DMD, PLLC

PATIENT REGISTRATION

Patient Name_____
(Last) (First) (Middle Initial) Preferred)

Phone#: Cell_____Home_____Work_____Email_____

How did you hear about our office? _____

DOB: _____ Social Security #_____ Driver's License # _____

Circle Male or Female Single or Married Child or Other_____

Address_____City_____State_____Zip_____

Employer_____Occupation_____

Emergency Contact_____ Phone#_____

ACCOUNT INFORMATION:

Individual Responsible for account _____Phone#_____

Relationship to patient _____ DOB: _____Social Security #_____

Address_____City_____State_____Zip_____

PRIMARY INSURANCE INFORMATION

_____

Policy Holders Name Date of Birth Name of Insurance

_____

Group ID# Member Id # Insurance Phone Number

ADDITIONAL/SECONDARY INSURANCE:

_____

Policy Holders Name Date of Birth Name of Insurance

_____

Group ID# Member Id # Insurance Phone Number

Authorization to pay benefits to dentist

I hereby authorize payment directly to the above dentist for the surgical and or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

Terms and conditions

Undersigned hereby authorize Advanced Dental Care to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Advanced Dental Care to make a thorough diagnosis of patient's dental needs. I also authorize Advanced Dental Care to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Dr. Elsa Flores choose and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand responsibility of payment for dentist services provided in the office for myself or my dependents is mine, due and payable at the time of services rendered unless financial arrangements have been made. I further understand that in the event of default I promise to pay legal interest on the indebtedness.

_____ _____

Patient/Guardian Signature **Date**

HEALTH AND DENTAL HISTORY

(Please Print) Patient First Name Last Name Date of Birth

Address City State Zip Phone

Please check Yes or No for those that apply to you.

YES	NO	
		Anemia
		Arthritis
		Artificial Heart Valve
		Artificial Joints
		Asthma
		Blood Disease
		Bruise Easily
		Cancer
		Chemotherapy
		Diabetes
		Dizziness
		Drug Addiction
		Emphysema
		Excessive Bleeding
		Fainting
		Glaucoma
		Heart Conditions
		Heart Lesions
		Heart Murmur
		Heart Surgery
		Hepatitis: A B C
		High Blood Pressure
		HIV Positive
		Jaundice
		Kidney Disease
		Liver Disease
		Low Blood Pressure
		Mitral Valve Prolapse
		Nervousness / Depression
		Pacemaker
		Radiation (Head / Neck)
		Respiratory Problems
		Rheumatic Fever
		Rheumatism
		Scarlet Fever
		Seizures
		Stomach Problems
		Stroke
		Thyroid Disease
		Tobacco Use
		Tuberculosis
		Ulcers
		Venereal Disease

Women Only

YES	NO	
		Birth Control
		Nursing
		Pregnant:

Delivery Date: _____

Please list current medications and allergies or provide us a list to copy.

Physician's Name: _____Phone: _____

I certify the information recorded on this medical/dental form is correct. I understand it is my responsibility to notify Advanced Dental Care of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold Advanced Dental Care or its employees liable in the event of death or injury.

Please check Yes or No for those that apply to you.

YES	NO	
		Sensitivity to: Hot Cold Sweet
		Chipped / Broken Teeth
		Crooked or Tipped Teeth
		Loose Teeth
		Missing or Spaces between Teeth
		Catch Food between Teeth
		Dry Mouth or Constantly Thirsty
		Smoke or Use Chewing Tobacco
		Bleeding, Swollen or Irritated Gums
		Dissatisfied With Appearance of My Teeth
		Frequent Headaches
		Jaw Joint Pain
		Grinding or Clenching Teeth
		Uncomfortable or Uneven When I Bite My Teeth Together
		Clicking or Popping of Jaw
		Difficulty Opening or Chewing

Patient/Guardian Signature _____ Date: _____

Dr. Elsa Flores: _____Date: _____

PATIENT PRIVACY DIRECTIVE

In our effort to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave messages at home cell phone to discuss appointments? **Yes No N/A**

May we text you messages to confirm or discuss your appointments? **Yes No N/A**

May we email you to confirm or discuss appointments or treatment? **Yes No N/A**

May we leave messages with or discuss your appointments/treatment with your spouse?

Spouses Name:_____ **Yes No N/A**

If you are over the age of 18, still living at home, may we discuss your appointments/treatment with your parent(s) or guardian?

Name:_____ **Yes No N/A**

If you are over the age of 18, may we discuss your appointments/treatment with your children?

Name: _____ **Yes No N/A**

What is the best way to communicate with you? Please list in order the best form of communication.(i.e.: cell/text/home/email)

1._____ 2. _____ 3. _____ 4. _____

Any other additional contact may be listed here._____

Social Media I like use: Google Yelp Yahoo Facebook

You must inform us, in writing, of any changes in your directives. This record takes effect upon signing and dating this form. It will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

I acknowledge I have received a copy of the "Notice of Privacy Practices"

Patient/Guardian Signature:_____ **Date:**_____

Printed Name:_____ **Date of Birth:**_____

Relationship to Patient:_____ **Pt Name:**_____ **Date of Birth:** _____

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

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) 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 witting 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 health information including those related to disclosures to family members, other relatives, close personal 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 in writing to remove it.
- The right to reasonably 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 obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information to provide you with notice of our legal duties and privacy practice with respect to protect health information.

This notice is effective as of April 14th, 2003 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, retaliate against you for filling a complaint.

- For Information about HIPAA or to file a Complaint: The U.S. Department of Health & Human Services Office of Civil Rights – 200 Independence Avenue, S.W. Washington, D.C. 20201 – (202)619-0257 – Toll Free: 1-877-696-6775

Patient Consent Form

You May Refuse to Sign This 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 have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient/Guardian Signature:_____ **Date:**_____

Printed Name:_____ **Date of Birth:**_____

Relationship to Patient:_____ **Pt Name:**_____ **Date of Birth:** _____

OFFICE POLICIES

It is your responsibility to keep all appointments. If you cannot keep your scheduled appointment time, in consideration of other patients in need of treatment, we kindly ask that you give the office a **48-hour advance notice**, so that we may offer your reserved time to another patient who is in need of our care. **In case of less than 48 hour notice of cancellation or no show a fee of $75.00 will be charged to your account. If I am more than 15 minutes late for my cleaning appointment, I will either take my remaining time only or reschedule.**

Payments are due at the time of visit. This includes all Co-pay's, co-insurance, and deductible amounts, for your convenience we accept Cash, Check, Visa, and MasterCard.

Return checks "any bad check can and will be turned over to the justice of the peace if the account is not reconciled within 20 days." You will also be responsible for a returned check fee in the amount of $25.

If a minor is brought in for treatment, the adult seeking the treatment is responsible for payment, regardless of who carries the insurance policy or who has custody.

INSURANCE POLICIES

We participate in several dental plans. It is *your responsibility* to verify that we do participate on your plan. It is also your responsibility to know the terms, limitations, and benefits of your plan. If we file insurance on your behalf, we need a copy of your current insurance card; you are required by your insurance company to pay all co- pay's, coinsurance, and deductibles which are due and payable at the time of service.

Verification of your insurance does not guarantee payment. Payment is subject to review by your insurance company. Payment is determined upon the actual receipt of the claims by the insurance company. If your insurance denies payment for services, you will be billed and it is your responsibility to pay for the service within 45 days of the date of treatment. It is your responsibility to contact your insurance company to dispute any denial, or nonpayment issues. We will be happy to assist you in preparing forms or printing receipts for you to file with your insurance company.

I, _____, Patient/Responsible Party have read the above and understand the policies regarding office and insurance policies. I agree to comply with all policies and agree to be responsible for payment of all services provided.

SIGNATURE_____ **DATE** _____

FINANCIAL AGREEMENT:

I, _____, Patient/Responsible Party understand that any service performed for my dependent or me by Dr. Elsa Flores or her office is my personal financial responsibility. If I have dental insurance I understand that it is not Dr. Flores office's responsibility to collect from my insurance company.

Dr. Elsa Flores' office will file an initial insurance claim on my behalf as a service to me at no additional cost. If my insurance carrier has not responded within 45 days of the date of the service, the entire fee for the service is due and payable by me. I understand any remaining balance regardless of the amount of the insurance payment is my responsibility.

SIGNATURE_____ **DATE** _____