Welcome to Arguello Dentistry, LLC

Whom May We Thank for Referring You? _____

About You

Patient Name: _____ Date of Birth: ___/___/___

First Name **Last Name**

Gender: □ Male □ Female Soc. Sec. # ____-____-____

Home Address: _____City: _____State____ Zip: _____

Home phone# _____-_____-_____ Cell phone #: _____-_____-_____

Email: _____

Check One That Applies: □Married □Single □Minor

Preferred contact method (check one that applies): □Phone □Text □E-mail □All

*For HIPAA: I hereby give permission to share any information concerning me with the person(s) named:

Name: _____ Name: _____

What is your primary language? _____

In case of Emergency: Name someone we may contact:

Name: _____Phone #_____-_____-_____ Relation: _____

Person Responsible For Account Mark if Same As Above ( )

Name: _____ Date of Birth: ___/___/___ Relation: _____

Billing Address: _____ City: _____ State: ___ Zip: _____

Soc. Sec. # ____-____-____ Phone #: _____

Medical History

1. Have you taken any medication or drugs during the past two years?	Yes	No
2. Are you currently taking any medication, drugs, or pills? If yes, please list medications:_____	Yes	No
3. Are you aware of being allergic to or have you ever reacted badly to any medication or substance? If yes, please specify:_____	Yes	No
4. Have you lost or gained more than 10 pounds in the past year?	Yes	No
5. Have you been diagnosed with cancer or a tumor? If yes, where? _____	Yes	No
6. Do you use tobacco products (smoke or chew tobacco)? If yes, how often and how much? _____	Yes	No
7. Do you drink alcoholic beverages? _____	Yes	No

Please indicate which of the following you have had, or currently have. Circle "Yes" or "No" for each item:

Allergies or Hives	**Yes**	**No**	Hepatitis A(infectious), B (Serum) or C	**Yes**	**No**
AIDS /HIV	**Yes**	**No**	Liver Disease	**Yes**	**No**
Anemia	**Yes**	**No**	Mitral Valve Prolapse	**Yes**	**No**
Arthritis	**Yes**	**No**	Nervousness	**Yes**	**No**
Artificial Heart Valve	**Yes**	**No**	Pain in Jaw Joints	**Yes**	**No**
Artificial Joints (Hip, Knee, etc.)	**Yes**	**No**	Psychiatric Treatment/Conditions	**Yes**	**No**
Asthma	**Yes**	**No**	Rheumatic Fever	**Yes**	**No**
Chemotherapy or Radiation Therapy (circle all that apply)	**Yes**	**No**	Rheumatism	**Yes**	**No**
Chronic Cough	**Yes**	**No**	Sickle Cell Disease	**Yes**	**No**
Cold sores/ Fever blisters/ Herpes	**Yes**	**No**	Stroke	**Yes**	**No**
Cosmetic Surgery	**Yes**	**No**	Thyroid Problems	**Yes**	**No**
Diabetes Type: _____	**Yes**	**No**	Tuberculosis	**Yes**	**No**

Drug Addiction	**Yes**	**No**	Ulcers	**Yes**	**No**
Epilepsy or Seizures	**Yes**	**No**	Venereal Disease	**Yes**	**No**
Emphysema	**Yes**	**No**	Yellow Jaundice	**Yes**	**No**
Fainting or Dizzy Spells	**Yes**	**No**	Any Physical or Mental Limitations?	**Yes**	**No**
Glaucoma	**Yes**	**No**	Had any injuries to teeth, mouth, head, or neck?	**Yes**	**No**
Heart Disease, Heart Attack, Heart Surgery, Heart Failure (circle all that apply)	**Yes**	**No**	**For Women Only**: Are you pregnant?	**Yes**	**No**
Heart Murmur or Pacemaker (circle all that apply)	**Yes**	**No**	Are you nursing?	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	Are you taking birth control pills?	**Yes**	**No**

Has the patient been told by physician that he/she needs to take antibiotics before dental treatment? _____
Has the patient had an operation? If yes, please specify _____
Are there any other conditions or concerns not listed above? If Yes, please specify:_____

I certify that I have read and understand the above. I acknowledge that the questions above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date**: ____/_____/_____

Current Dental Conditions

Please Check All That Apply:

- ☐ Toothache
- ☐ Broken filling or tooth
- ☐ Sensitivity to:
  - ☐ Cold
  - ☐ Hot
  - ☐ Sweets
  - ☐ Chewing
- ☐ Food catches
- ☐ Unable to open mouth wide
- ☐ Bite or teeth have shifted
- ☐ Often bite cheeks
- ☐ Frequent dry mouth
- ☐ Concerned about breath
- ☐ Unhappy with previous dental work
- ☐ Gums bleed / tender
- ☐ Loose Teeth
- ☐ Cold sores, fever blisters
- ☐ Wore braces
- ☐ Cracked, chapped lips
- ☐ Sinus problems
- ☐ Jaw joint pain
- ☐ Mouth breathe – asleep or awake
- ☐ Clench or grind teeth
- ☐ Clicking or popping of joint
- ☐ Jaw gets tired easily
- ☐ Floss breaks easily or hurts

Please thoroughly read each policy, initial next to each policy and sign below:

Treatment Agreement

_____ I promise full cooperation with my treating dentist. I understand that if I do not follow my doctor's instructions concerning my care and treatment the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

_____ For the purpose of payment, I allow Arguello Dentistry by the Sea to release my Private Health Information to all my insurance carriers, their third payors and claim reviewers, until the claim is resolved. I also allow the above listed practice to release my information or contact all my treating physicians.

_____ I promise to provide complete and accurate information to the doctors about my health and medications, including over the counter products. I also understand my responsibility to be respectful of the doctors, staff, and other patients. Inappropriate behavior will result in immediate termination of the doctor/patient relationship.

Acknowledgement of Receipt of Notice of Privacy Practices

_____ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Financial and Appointment Policy

_____ No insurance pays 100% of all procedures. Dental insurance is meant to be an aid in receiving dental care. Benefits *are not* determined by our office. Not all services are a "covered" benefit in all insurance policies. If you want to know what will be paid on a procedure, we would be happy to submit a pre-determination to your insurance company. As a courtesy, we will file your insurance claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. By law your insurance company is required to pay each claim within 30 days of receipt. If your insurance company does not pay for any claims for any reason after 60 days of the date of service, you will become financially responsible for their portion and payment to the office must be rendered immediately and you will need to seek reimbursement directly from your insurance. *I fully understand that in the event my insurance company does not pay for the services I received; I will be financially responsible for payment of services rendered.*

_____You must provide personal (address, phone numbers, etc.) and/or insurance changes (policy name, insurance company address, or a change of employment) to the office *prior* to your appointment. Failure to provide such information prior may result in the appointment needing to be rescheduled.

_____ Occasionally, an appointment will wish to be made for a spouse, older child, elderly relative, etc. We prefer that patients make their own appointments to prevent any miscommunication regarding date, time, or treatment to be provided. We will accept these appointments, but the person calling on your behalf *must* be listed as an authorized person who we can relay your personal information to. Appointments made by such persons are subject to all the other rules and expectations of appointments made personally.

_____Your portion of payment for ALL office services is due at the time of service. Our office accepts: Cash or check, VISA, MasterCard, American Express, Discover Card, or FSA/HSA. Special financing options with convenient monthly payments are also available with the CareCredit healthcare credit card. For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans a deposit is required to secure your treatment appointment. A deposit is required for certain appointment times.

_____ We do our best to not over-book our schedule. This means your appointment time is reserved especially for you. If you do not come, not only is your own care delayed, but no one else is able to be treated during that time. If you absolutely must reschedule, please give at least 24 hours' notice (before 9 am Friday for Monday appointments) to avoid possible broken appointment fees. In some cases, especially for large appointment space, you may be asked to give greater notice. There is generally no charge for the first missed appointment without 24 hours' notice. To discourage repetitive broken appointments, we may asses a broken appointment charge for the second and each subsequent occurrence. The charges are dependent on how much time was reserved for you and your need ($25 - $100 per hour (based on type of treatment scheduled). Repetitive broken or cancelled appointments and/or non-compliance may result in transfer of your care to an alternative practice.

_____ We understand traffic and other delays may cause you to run late to your appointment. Please call the office if you are running late and we will see if the doctor's schedule allows for your appointment to be kept or if we need to reschedule. Late arrivals of 15 minutes or more may automatically result in the appointment needing to be rescheduled. A broken appointment fee may be assessed in certain cases.

_____PAST DUE accounts are subject to collection proceedings including the credit bureau. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office. Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the doctor/patient relationship.

_____If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. There is a service fee of $30.00 for all returned checks.

If you do not understand any of the above, please ask a staff member.

I certify that I have read and understand all the above.

Print Patient Name: _____

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