thank you for selecting us.

GABLES EXCEPTIONAL DENTISTRY
Mirtha Amador, DMD
357 Almeria Ave., Suite 105 • Coral Gables, FL 33134
Phone 305•569•9001

Today's Date _____

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____ Sex _____ Age _____

Nickname _____ SS#/SIN _____ Birthdate _____

School _____ Grade _____

Child's Home Address _____

City _____ State/Prov. _____ Zip/P.C. _____ Phone _____

Responsible Party

Name _____ Relationship _____

Address _____ Email _____

City _____ State/Prov. _____ Zip/P.C. _____

Home Phone _____ Cell Phone _____ Work Phone _____

SS#/SIN _____ DL # _____

Who is Responsible for Making Appointments? _____

Parent or Guardian Information

Relationship to Patient _____

Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

SS#/SIN _____ DL # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Whom may we thank for referring you to our practice? _____

Primary Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Phone # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Additional Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Phone # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Over Please

Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated?	☐ Yes	☐ No
Does your child take fluoride supplements?	☐ Yes	☐ No

Does your child:

Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No

Date of Last Dental Visit _____

Previous Dentist _____

Phone # _____

Address _____

Has your child had difficulty with previous dental visits?	☐ Yes	☐ No
Has your child ever taken Fen-Phen/Redux?	☐ Yes	☐ No

Has your child ever had any of the following:

Asthma	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐ Yes	☐ No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses When?

_____ _____

_____ _____

Is your child currently taking any medications? ☐ Yes ☐ No (if yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ☐ Yes ☐ No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

_____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card Card #_____ Exp._____ Security Code_____ ☐ Care Credit

AUTHORIZATION & RELEASE

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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient (or Parent/Guardian if minor) Date

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HIPAA
Acknowledgement of Receipt of Notice of Private Practices

The undersigned acknowledges receipt of a copy of current effective Notice of Privacy for Gables Exceptional Dentistry. A copy of this signed and dated acknowledgment shall be effective as original.

Please print your full name. A signature will be requested when you arrive for your appointment.

If you are the legal representative of the patient, please print the patient's name and describe your authority or relationship to patient:

Patient/ Parent/Guarantor Signature:_____Date: _____

CONSENT TO TREATMENT/TRUTH IN LEADING DISCLOSURE

I, the undersigned, do consent to dental examination, diagnosis, and treatment for myself or child _____ by Mirtha Amador, DMD and her trained professional staff. I consent to the transfer of my previous dental records to my doctor from any previous provider(s). This consent includes the use of local anesthetic agents, the exposure of dental x-rays, and the insertion of restorative and prosthetic materials into the mouth and teeth. I understand that the usefulness and longevity of any dental treatment or restoration is extremely variable and individual.

I understand that my proposed treatment may change according to changing conditions in my mouth.

A fee of $40 will be charged to my account for any missed or cancelled appointment(s) unless changes are made with more than 48 hours notice. I am aware of a $30 return check fee and a 1.5% per month interest incurred on any balance over 30 days.

Financial arrangements must be made in advance of any treatment. I understand that I am financially responsible for treatment regardless of insurance benefits or denials.

I, THE UNDERSIGNED agree, whether I sign as patient, parent, spouse, guarantor or guardian, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account. Should the account be rendered to the attorney for collections, I authorize an attorney to obtain my credit report; and I, the undersigned, will be responsible for of all costs and expenses, including all attorney and collections agency costs.

I agree and consent to all the above and understand that I may receive a copy of this statement.

Please print:

Patient's Name: _____

Relationship to Patient: _____

Social Security No.: _____

Patient/Parent/Guarantor Signature:_____Date: _____