GABLES EXCEPTIONAL DENTISTRY

WELCOME

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

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____

Birthdate _____

SS #/SIN _____ E-Mail _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____ Occupation _____

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

2 Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver's License # _____

SS #/SIN _____

Address _____ E-Mail _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

3 Telephone

Home Phone _____

Work Phone _____ Ext. # _____

Cell Phone _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

4 Dental Insurance Information

Primary Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
SS #/SIN _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Phone # _____
Group # _____
Employee/Cert. # _____
Ins. Co. Address _____
Deductible _____
Amount already used _____
Max. annual benefit _____

Additional Insurance

Name of Insured _____
Relationship to patient _____
Insured's birthdate _____
SS #/SIN _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Phone # _____
Group # _____
Employee/Cert. # _____
Ins. Co. Address _____
Deductible _____
Amount already used _____
Max. annual benefit _____

5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental 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.

X _____

Signature of patient or parent/guardian if minor Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash
_____ Personal Check
_____ Credit Card Card #_____ Exp:_____ Security Code_____
_____ Care Credit

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

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Health History

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

NAME _____ **BIRTHDATE** _____ **TODAY'S DATE** _____

A Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ❒ Soft ❒ Medium ❒ Hard

	YES	NO
5. Do your gums bleed while brushing?	❒	❒
6. Do your gums bleed when flossing?	❒	❒
7. Do you feel pain to any of your teeth when brushing or flossing them?	❒	❒
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	❒	❒
9. Have you noticed any loosening of your teeth?	❒	❒
10. Does food tend to become caught between your teeth?	❒	❒
11. Do you have any sores or lumps in or near your mouth?	❒	❒
12. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	❒	❒
b. Pain (joint, ear, side of face)?	❒	❒
c. Difficulty in opening or closing?	❒	❒
d. Difficulty in chewing?	❒	❒
13. Have you had any head, neck or jaw injuries?	❒	❒
14. Do you have frequent headaches?	❒	❒
15. Do you clench or grind your teeth while awake or asleep?	❒	❒
16. Do you bite your lips or cheeks frequently?	❒	❒
17. Have you ever had:		
a. Orthodontic treatment (braces)?	❒	❒
b. Oral surgery?	❒	❒
c. Gum treatment?	❒	❒
d. Your teeth ground or the bite adjusted?	❒	❒
e. Worn a bite plate or other appliance?	❒	❒
18. Are you satisfied with the appearance of your teeth?	❒	❒
19. Have you ever had an upsetting experience in the dental office?	❒	❒
20. Is there anything about having dental treatment that bothers you?	❒	❒

B Medical History

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 that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health?	❒	❒
2. Have there been any changes in your general health within the past year?	❒	❒
3. Date of your last physical exam: _____		
4. Physician's name _____ Address _____ Phone No. _____		
5. Are you now under the care of a physician?	❒	❒
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. _____	❒	❒
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? _____	❒	❒
8. Have you ever taken Fen-Phen/Redux?	❒	❒
9. Have you had any abnormal bleeding?	❒	❒
10. Do you bruise easily?	❒	❒
11. Have you ever required a blood transfusion?	❒	❒
12. Have you had a recent weight loss?	❒	❒
13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❒	❒
14. Do you use tobacco?	❒	❒
15. Do you use alcohol or cocaine or other drugs?	❒	❒
16. Are you wearing contact lenses?	❒	❒
17. Do you have any disease, condition or problem not listed above that you think I should know about?	❒	❒
Women Only:		
1. Are you pregnant or think you may be pregnant?	❒	❒
2. Are you nursing?	❒	❒
3. Are you taking birth control pills?	❒	❒

(OVER)

C Medical History Continued...

	YES	NO
Are you allergic to or have you had reactions to:		
1. Local anesthetics like novocaine?	❒	❒
2. Penicillin or other antibiotics?	❒	❒
3. Sulfa drugs?	❒	❒
4. Barbiturates, sedatives or sleeping pills?	❒	❒
5. Aspirin?	❒	❒
6. Iodine?	❒	❒
7. Other?_____	❒	❒
Do you have or have you ever had the following:		
1. Rheumatic heart disease or rheumatic fever?	❒	❒
2. Heart defect or heart murmur?	❒	❒
3. Heart trouble, heart attack or angina?	❒	❒
a. Do you have pain in your chest upon exertion?	❒	❒
b. Are you ever short of breath after mild exercise?	❒	❒
c. Do your ankles swell?	❒	❒
d. Do you get short of breath when you lie down?	❒	❒
e. Do you require extra pillows when you sleep?	❒	❒
4. Pacemaker?	❒	❒
5. Heart surgery?	❒	❒
6. High blood pressure?	❒	❒
7. Low blood pressure?	❒	❒
8. Hepatitis, jaundice or liver disease?	❒	❒
9. Stroke?	❒	❒
10. Sinus trouble?	❒	❒
11. Lung or breathing problems?	❒	❒
12. Asthma or hay fever?	❒	❒
13. Hives or skin rash?	❒	❒
14. Fainting spells or seizures?	❒	❒
15. Diabetes?	❒	❒
16. AIDS or HIV infection?	❒	❒
17. Thyroid problems?	❒	❒
18. Allergies?	❒	❒
19. Arthritis or rheumatism?	❒	❒
20. Joint replacement or implant?	❒	❒
21. Stomach ulcer?	❒	❒
22. Kidney trouble?	❒	❒
23. Tuberculosis?	❒	❒
24. Persistent cough?	❒	❒
25. Cough that produces blood?	❒	❒
26. Cancer?	❒	❒
27. Sexually transmitted disease?	❒	❒
28. Epilepsy?	❒	❒
29. Anemia?	❒	❒
30. Leukemia?	❒	❒
31. Glaucoma?	❒	❒

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 _____

For Completion By The Dentist:

SUMMARY OF DENTAL HISTORY

_____

_____

_____

_____

SUMMARY OF MEDICAL HISTORY

_____

_____

_____

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	INITIALS: PATIENT	DENTIST	HYGIENIST

GABLES EXCEPTIONAL DENTISTRY

Mirtha Amador, DMD
357 Almeria Ave., Suite 105
Coral Gables, FL 33134
Phone 305-569-9001

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: _____