OTERO FAMILY, COSMETIC & IMPLANT DENTISTRY

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____

Patient Information:

Address: _____ Address 2:_____
City: _____State/Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birth Date: _____ Age: _____ Social Security Number: _____
Gender: ○ Male ○ Female How would you like to receive confirmations ○Call ○Text ○Email
Marital Status: ○Married ○Single ○Divorced ○Separated ○Widowed
To receive correspondence via email, please provide email address: _____
Employment Status: ○Full-time ○Part-time ○Retired ○Unemployed ○Disabled
Student Status: ○Full-time ○Part-time ○None If student: Name of School _____
Previous Dentist: _____ Date of Last Dental Visit: _____
Preferred Pharmacy: _____ Pharmacy # (if known): _____
Emergency Contact: _____ Emergency Contact #: _____
***Please list individuals with whom we may share information, including but not limited to, appointments, billing and treatment. If no one other than yourself, please check here:** ☐ **Only Myself**
1. _____ 2. _____

Responsible Party (if someone other than patient):

First Name: _____Last Name: _____Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birth Date: _____ Age: _____ Social Security Number: _____
Relationship to Patient: ○Spouse ○Parent ○Insurance Holder ○Other (please specify) _____

Primary Dental Insurance Information:

Name of Insured: _____
Relationship to Insured: ○Self ○Spouse ○Child ○Other (please specify) _____
Insured Soc. Sec #: _____ Insured Birth Date: _____
Employer: _____
Employer Address: _____
Insurance Company: _____
Insurance Company Address: _____
***Please provide us with your insurance card so we may make a copy for your records**

Secondary Dental Insurance Information:

Name of Insured: _____
Relationship to Insured: ○Self ○Spouse ○Child ○Other (please specify) _____
Insured Soc. Sec #: _____ Insured Birth Date: _____
Employer: _____
Employer Address: _____
Insurance Company: _____
Insurance Company Address: _____
***Please provide us with your insurance card so that we may make a copy for your records**

OTERO FAMILY, COSMETIC & IMPLANT DENTISTRY

This document outlines some of our important office policies. Please initial to acknowledge that you have read, understand, and agree to each policy. Please complete and sign the bottom of the page.

FINANCIAL POLICY

It is our pleasure to bill your insurance as a courtesy. However, the patient receiving service (or their legal guardian) is ultimately responsible for all fees incurred. We require you to pay the estimated "patient portion" at the time of service. This may include a deductible, copay, and/or a percentage of each procedure. If your insurance has not made payment in full within 2 months of treatment, you are responsible for paying your balance. We accept cash, checks, VISA, American Express and Mastercard. We also offer financing through Care Credit.

Please initial: _____

LATE POLICY and CANCELLATION POLICY

We reserve time for each patient and do our best to stay on schedule. Please help us by arriving on time to your appointments. If you will be late to your appointment, please call our office. We may be able to see you at the time you arrive. However, to be fair to other scheduled patients, we may need to reschedule your appointment.

If you need to cancel or reschedule your appointment, kindly give us at least 24 hours notice. This allows us a chance to help other patients during the time we had reserved for you. Wasted appointment time leads to higher dental care cost for everyone. Therefore, in order to control dental care costs for our patients, if 24 hours notice is not given, we must charge a non-refundable cancellation fee of $25 per hour of appointment time which will not be covered by your insurance. Failure to give 24 hours notice three times may result in dismissal from the practice.

Please initial: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

This practice will provide a detailed notice of our privacy practices to patients and to anyone else who requests a copy. The notice and the way it is provided will comply with HIPAA and applicable state law. This practice will not use or disclose patient information in a manner that is inconsistent with the notice, HIPAA, or state law. I acknowledge that I have received (if requested) a copy of this office's Notice of Privacy Practices. I understand that, by signing below, I am authorizing members of Otero Family, Cosmetic & Implant Dentistry and their employees to disclose information about my past and future dental treatment to insurance companies, pharmacies and to other dental professionals and physicians as needed so that I may be provided with the best comprehensive care possible.

Please initial: _____

RELEASE OF APPOINTMENT INFORMATION

I give Otero Family, Cosmetic & Implant Dentistry permission to send postcards and leave messages regarding appointment times and purposes. They may leave messages on an answering machine, voicemail, text message or with persons answering the phone at any of the phone numbers and/or email addresses I give them. I will be able to sign an additional release form if I would like to give permission for this practice to share information about my dental appointments with anyone other than those specified above.

Please initial: _____

I verify that I have read, understand, and agree to all the above policies.

Signed_____**Date**_____

Office Use Only: Unable to obtain due to:
○ Refusal ○Communication Barrier ○Emergency Situation ○Other (please specify) _____

OTERO FAMILY, COSMETIC & IMPLANT DENTISTRY
MEDICAL HISTORY

Patient Name: _____Date of Birth: _____

Although your dental team will be primarily treating the area in and around your mouth, your mouth is a part of your entire body. Your health history, including medication that you may be taking, has an important interrelationship with the dental care you will receive. For your safety and optimal care, we thank you for answering the following questions.

Are you currently under a physician's care? ○Yes ○ No
If yes, please explain: _____
Have you ever been hospitalized or had a major surgery? ○Yes ○ No
If yes, please explain: _____
Have you ever had a serious head or neck injury? ○Yes ○ No
If yes, please explain: _____
Are you on a special diet? ○Yes ○ No
If yes, please explain: _____
Do you take, or have you ever taken, Phen-Fen or Redux? ○Yes ○ No
If yes, please explain: _____
Have you ever taken Zometa, Aredia or any other Bisphosphonate drugs? ○Yes ○ No
If yes, please explain: _____
Do you use any controlled substances? ○Yes ○ No
If yes, please explain. Include type and frequency: _____
Do you drink alcohol? ○ Yes ○ No
If yes, how many drinks per week on average? _____
Do you use tobacco of any kind? ○Yes ○ No
If yes, please explain. Include type and frequency: _____

Women:

Pregnant/trying to get pregnant? ○Yes ○ No
Taking oral contraceptives? ○Yes ○ No
Nursing? ○Yes ○ No

Are you allergic to the following?

□ Sulfa □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Aspirin
□ Other If yes, please explain: _____

Please circle below all that apply now or in the past. If none, please initial here: _____

AIDS/HIV	Diabetes	Hemophilia	Radiation Treatments
Alzheimer's Disease	Drug Addiction	Hepatitis A	Renal Dialysis
Anaphylaxis	Emphysema	Hepatitis B or C	Rheumatic Fever
Anemia	Epilepsy or Seizures	Herpes (oral/genital)	Scarlet Fever
Angina	Excessive Bleeding	High Blood Pressure	Shingles
Arthritis/Gout	Excessive Thirst	High Cholesterol	Sickle Cell Disease
Artificial Heart Valve	Fainting/Dizziness	Hives and Rash	Sinus Trouble
Artificial Joint	Frequent Cough	Hypoglycemia	Stomach/Intestinal Disease
Asthma	Frequent headaches	Irregular Heartbeat	Stroke
Blood Disease	Glaucoma	Kidney Problems	Swelling of Limbs
Blood Transfusion	Hayfever/allergies	Leukemia	Thyroid Disease
Breathing Problem	Heart Attack	Liver Disease	Tonsillitis
Bruise Easily	Heart Disorder (congenital)	Low Blood Pressure	Tuberculosis
Cancer	Heart Failure	Lung Disease	Tumor or Growth
Chemotherapy	Heart Murmur	Mitral Valve Prolapse	Ulcers
Chest Pains	Heart Pacemaker	Pain in Jaw Joints	Venereal Disease
Cold Sores/Fever Blisters	Heart Trouble	Psychiatric Care	Unexplained Weight Loss
			Yellow jaundice

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MEDICAL HISTORY (PAGE 2)

Have you ever had any serious illness not listed on the previous page? ○ Yes ○ No
If yes, please explain:

_____
_____
_____

Are you currently taking any medications? ○Yes ○ No
If yes, please list and give the reason for taking each one. Please include vitamins and herbal remedies.

_____
_____
_____
_____
_____

Questions, comments, or anything else you would like us to know about you:

_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

SIGNATURE OF PATIENT (AND/OR LEGAL GUARDIAN IF PATIENT IS UNDER 18):

_____

DATE: _____

OTERO FAMILY, COSMETIC & IMPLANT DENTISTRY

DENTAL HISTORY

How did you hear about our office?

- MAGAZINE TELEVISION INTERNET FRIEND OTHER_____

What is the reason for your visit today? _____

Have you ever had a negative dental experience? _____
If yes, please tell us about it so that we can improve your experience with us:

When was your last dental visit? _____
How often do you brush your teeth? _____
How often do you floss your teeth? _____
Do you use an electric toothbrush? _____

Please circle any of the following that apply to you:

Sensitive teeth	Bleeding gums	Difficulty opening
Loose teeth	Clench/grind teeth	Pain or popping in jaw
Dentures/partials	Mouth ulcers	Pain or numbness in mouth
Discolored teeth	Crowded teeth	Braces/orthodontics

SMILE EVALUATION

Do you like the color of your teeth? _____

Do you like the size and shape of your teeth? _____

Do you like the position of your teeth? _____

Are you happy with the overall appearance of your smile? _____

Have you ever had cosmetic dental work? _____