PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient Name:_____ Date:_____
Last First MI

Preferred Name:_____ DOB:_____ SS#_____

◯ Male ◯ Female ◯ Minor ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Address_____

_____

City State Zip Code

I authorize appointment details to be left on the following contact numbers:

Home:_____ Cell:_____ Work:_____

Email:_____

Responsible Party:

◯ Self (continue to next section)

Name:_____ Relationship to patient:_____

Address:_____ Telephone number:_____

In Case of an Emergency:

Emergency contact:_____ Relationship:_____

Address:_____ Phone Number:_____

Employment Information:

Employer Name:_____ Occupation:_____

Address:_____ Telephone Number:_____

Dental Insurance Info:

Insured Name:_____ Date of Birth_____ Relationship to PT:_____

SS#_____ Group#_____ ID#_____

Employer:_____ Ins Company:_____

Address:_____

Phone:_____

Medical Information:

General Physician:_____ Phone Number:_____

Are you under medical treatment now? _____ Yes _____ No

Have you been admitted to a hospital or needed emergency care during the past two years? _____ Yes _____ No (Please explain)

_____

Do you use tabacco?	Y	N	Do you drink alcohol?	Y	N
Do you use cocaine or other drugs	Y	N	Do you wear contact lenses	Y	N
Do you snore?	Y	N	Do you have trouble breathing at night?	Y	N

Allergies:

Are you allergic to, or have you had reactions to, any of the following?

Aspirin	Y	N	Barbiturates/Sleeping pills	Y	N
Codeine/Other Narcotics	Y	N	Erythromycin	Y	N
Iodine	Y	N	Latex Rubber	Y	N
Local Anesthetics	Y	N	Metals	Y	N
Epinephrine	Y	N	Penicillin	Y	N
Sulpha Drugs	Y	N	Other:_____	Y	N

Health Information:

Have you ever had any of the following? Please check those that apply:

__ AIDS	__ Fainting	__ Liver Disease	__ Stroke
__ Anemia	__ Glaucoma	__ Low Blood Pressure	__ Tuberculosis
__ Arthritis	__ Growth	__ Mental Disorders	__ Tumors
__ Artificial Joints	__ Hay Fever	__ Nervous Disorders	__ Ulcers
__ Asthma	__ Head Injuries	__ Pacemaker	__ Venereal Disease
__ Blood Disease	__ Heart Disease	__ Radiation	__ Other:_____
__ Cancer	__ Heart Murmur	__ Respiratory Problems	_____
__ Diabetes	__ Hepatitis	__ Rheumatic Fever	_____
__ Dizziness	__ High Blood Pressure	__ Rheumatism	
__ Epilepsy	__ Jaundice	__ Sinus Problems	
__ Excessive Bleeding	__ Kidney Disease	__ Stomach Problems	

Active Medication:

Are you taking any of the following medications:

_____ Aspirin _____ Blood Thinners _____ High Blood Pressure meds _____ Diabetic

Other (list all meds) :_____

_____

Dental History:

Do your gums bleed while brushing or flossing?	Y	N	Do you have frequent headaches?	Y	N
Are your teeth sensitive to hot or cold?	Y	N	Do you clench or grind your teeth?	Y	N
Are your teeth sensitive to sweet or sour?	Y	N	Do you bite your lips or cheeks frequently?	Y	N
Do you feel pain in any of your teeth?	Y	N	Have you ever had any difficult extractions	Y	N
Do you have any sores or lumps in or near			in the past?		
your mouth?	Y	N	Have you had any orthodontic work?	Y	N
Have you had any head, neck or jaw injuries?	Y	N	Have you ever had any prolonged bleeding		
Have you ever experienced problems with your jaw?	Y	N	following extractions?	Y	N

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fall.

_____ _____

Signature of Patient | Parent or Legal Guardian Date

PT Name:_____

MEDICAL AND DENTAL AUTHORIZATION RELEASE

I certify that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. _____ (initial)

APPOINTMENT REMINDER RELEASE

I authorize Family First Dental to leave appointment details on the contact numbers provided. _____ (initial)

INFORMED CONSENT AND PERMISSION FOR ANESTHETIC

Before you give your permission for the administration of anesthetic, you should understand there are associated risks. The possible general risks of local anesthetic may include allergic reactions, nausea, high or low pressure, and in extreme cases, cardiac arrest. There may be a remote possibility of nerve involvement resulting in temporary numbness or tingling of the lip, chin or tongue, and/or bruising at the site of administration._____ (initial)

INSURANCE AND FINANCIAL AUTHORIZATION

We will file your insurance claim for you. It is understood all charges connected with Family First Dental not covered by an insurance or a third party coverage are due and payable within 30 days of services rendered. By signing you agree you have read and fully understand the above language and agree to be personally responsible for any amount due.

I understand should I fail to pay my balance within 90 days of services rendered my delinquent account is subject to a collection agency unless financial arrangements have been made. If the account is referred to collection I will pay Family First Dental attorney fees, court costs, and/or collection agency fees associated with the collection process.

An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payments options. You can choose from Care Credit Healthcare Credit Card or Lending Club Patient Solutions. These plans allow you to pay over time with no annual fees or pre-payment penalties.

Family First Dental accepts personal checks but if a check is returned from your banking institution a $35.00 dollar fee will be charged for the first offense. If a (2nd) second check is returned we will not accept your personal checks in our office. We also accept Visa, Mastercard, Discovered and American Express as a form of payment. _____ (initial)

The principles of our practice are designed to foster a comfortable relationship with our patients.

1. Your first dental visit will include diagnostic x-rays and an oral exam by the dentist. At this time you will be presented with a treatment plan specifically designed to meet your dental needs. If you have had x-rays taken at another dentist office you may want to check your x-ray /exam frequency limits with your insurance carrier. Any treatment recommended will be scheduled at this time.
2. According to Florida Law, a cleaning done by a dental hygienist is considered a prescription. The dentist issuing such a prescription shall remain responsible for the care of such patient. This prescription is issued to a "patient of record" by a dentist and shall be valid 2 years. Family First Dental has a standard of care that requires such prescriptions to be renewed annually. In order to issue and/or renew a prescription, your dentist must take your complete medical history, complete a clinical examination, record any pathological conditions, and prepare a treatment plan. Family First Dental dictates a clinical examination must include a recent set of diagnostic x-rays. In the event recent x-rays cannot be provided, we will take them unless indicated otherwise by your medical Doctor. Hence you will be required to have an exam and x-rays once a year to continue to receive cleanings.
3. Payment is due when services are rendered. You may use cash, Visa, Mastercard, Discover, American Express or payment by personal checks. We can not make payment arrangements. We do offer Care Credit, an outside financing option with interest free-plans.
4. Insurance for most PPO and traditional plans are submitted by our office. We currently are not contracted with any HMO insurance. When you are given a treatment plan, PLEASE BE AWARE THAT THIS IS ONLY AN ESTIMATE. There may be a minor balance due once the final payment is made by your insurance company. We ask that you be familiar with your insurance plan and benefits, with its exclusions, frequencies, deductibles, and maximums, as you expect us to be. If your insurance coverage changes, it is your responsibility to notify our office before your next dental visit, as this will take time to verify and enter the new information in our system. Please remember, filing insurance for our patients is a courtesy.
5. By Law, children under the age of (18) eighteen years old may not attend the first dental appointment without being accompanied by their parent. All paperwork must be signed by their legal guardian. We ask that younger children always be accompanied by their parent to all dental visits. If the parent is not able to be present, then someone of legal age must accompany the child along with a written notice authorizing the person to represent them. PLEASE DO NOT DROP OFF YOUR CHILD TO ATTEND DENTAL VISITS ALONE. Parents need to be available to discuss dental treatment for each appointment. As a rule, we ask parents to remain in the outer reception area. We would like to build trust with each child as well as their parents.
6. PLEASE REMEMBER, A CONFIRMATION CALL OR TEXT FROM OUR OFFICE IS A COURTESY. Appointments are confirmed at least one day in advance. We ask for a confirmation return call from each patient. If you do not call back to confirm your appointment we will assume that you are unable to come and we will schedule someone else in your appointment slot. If you do not call within (24) twenty-four hours in advance to change or cancel an appointment, we reserve the right to charge a minimum of $40.00 per appointment or for every hour reserved (whichever is greater). Please be considerate of others and contact our office (1) one day prior if you are unable to attend your appointment. Another patient may then be called to accept the appointment time which is left open. A patient can be dismissed from our practice after (3) three missed appointments without calling in advance or too many re-schedule of the same appointment. We are unable to secure a doctor/patient relationship when our patients do not attend their appointments.
7. It is our commitment to practice high-quality dentistry. This means we do not practice dentistry to meet the needs of your insurance coverage. We practice dentistry to fulfill the need of the patient. We will not neglect your dental health to restore only what y our insurance company will pay for.

Thank you for choosing Family First Dental and Dr. Mosquera as your dental office. "Our Family Caring for Yours"

_____ _____

Signature of Patient | Parent or Legal Guardian Date