Ornelas Family Dentistry
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's name _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home phone _____ Cell phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

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

BILLING AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____ Member ID#_____

Spouse's birthday _____ Spouse's social security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

Medication List

-Please list any medications including dosages you have taken OTC or prescribed in the past year

- Please report if you have ever had any BISPHOSPHONATE medications either IV or oral (Zometa, Aredia, Fosamox, Boniva…).

I certify that I have read and I understand the questions on this form. I will not hold my dentist or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient (or guardian):_____ Date: _____

Ornelas Family Dentistry Office Policy

Authorization to Release info and Assignment of Benefits: I certify that I, _____ (or my dependent) Have (has) dental insurance coverage and assign directly to Ornelas Family Dentistry all insurance benefits, if any, otherwise payable to me for service rendered. I hereby authorize the doctors and staff to release all necessary personal information to carry out treatment, payment activities and health care operations.
Initial_____

Patients with Dental Insurance: As a courtesy to, and with your authorization, our office will submit to your insurance. For more specific information about your benefits, please call your insurance company, as you are responsible to know covered and non-covered benefits. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. We cannot, however, guarantee the actual payment of benefits once submitted and processed by the insurance. Keep in mind that insurance companies base payments off their own fee schedule, not our office's actual fees. Should an outstanding balance be due post insurance payment, a statement will be mailed to you. Payment in full is required by the due date printed on the statement. We do not allow partial payments. If a credit balance should result after insurance payment, a refund will be promptly sent to you. **If we are not provided with a social security number, payment in full is required, regardless of insurance.**
Initial_____

Unpaid Insurance Claims: All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will allow your insurance 60 days to remit payment. If there is still no payment after this time you will be responsible for 100% of the outstanding insurance claim. A statement will be sent to you and payment in full will be due by the date printed on your statement. It is the responsibility of the account holder to follow up with their own insurance regarding non-payment of a claim. Should our office eventually receive payment from the insurance, post personal payment, a refund will be issued promptly.
Initial_____

Patients without Dental Insurance: Full payment is required at time of service. We accept cash, check, all major credit cards, and Care Credit.

Initial_____

Past Due Accounts: If payment is not received by the statement due date, your account will be considered "past due." We reserve the right to charge your account a rate of 1.5% or a minimum of $3.00 monthly. If the balance continues to go unpaid, the account will be turned over to an agency resulting in the patient's responsibility for ALL attorney/collection/court fees that this office incurs while attempting to collect the debt. Initial_____

Ornelas Family Dentistry reserves the right to update and make changes to the above stated policy at any times without prior notification

By signing below, I verify that I completely understand, agree and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered by me or my dependents.

Signature_____ Date_____