Patient Information

Patient Name: _____ Date:_____

Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____/____/_____ Birth Date: ____/____/_____ Best time to call: AM_____ PM_____

Phone (Home): (____)_____ (Work): (____)_____ Cell: (____)_____

E-Mail:_____ ☐ I would like to receive correspondences via e-mail ☐ Text Msg.

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐ M ☐ T ☐ W ☐ T ☐ F

Address: _____

Street City State Zip Code

Emergency Contact: _____ Relationship:_____ Phone: (____)_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Referral Information

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

Do you have any other family member that comes to our practice?_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell):_____

Address: _____

Street City State Zip Code

Medical History

Patient Name: _____ Date:_____

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ YES ☐ NO *If yes, please explain:* _____

Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO *If yes, please explain:* _____

Have you ever had a serious head or neck injury? ☐ YES ☐ NO *If yes, please explain:* _____

Are you taking any medication, pills or drugs? ☐ YES ☐ NO *If yes, please explain:* _____

_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ YES ☐ NO *If yes, please explain:* _____

Are you on a special diet? ☐ YES ☐ NO *If yes, please explain:* _____

Do you use tobacco? ☐ YES ☐ NO *If yes, please explain:* _____

Do you use controlled substances? ☐ YES ☐ NO *If yes, please explain:* _____

Women: Are you

Pregnant ☐ YES ☐ NO | Trying to get pregnant ☐ YES ☐ NO | Taking oral contraceptives ☐ YES ☐ NO | Nursing ☐ YES ☐ NO

Are you Allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex

☐ Sulfa Drugs ☐ Other *please specify:* _____

Please check Yes or No to the following: _____

- ☐ YES ☐ NO AIDS/ HIV Positive
- ☐ YES ☐ NO Alzheimer's Disease
- ☐ YES ☐ NO Anaphylaxis
- ☐ YES ☐ NO Anemia
- ☐ YES ☐ NO Angina
- ☐ YES ☐ NO Arthritis/Gout
- ☐ YES ☐ NO Artificial Heart Valve
- ☐ YES ☐ NO Artificial Joint
- ☐ YES ☐ NO Asthma
- ☐ YES ☐ NO Blood Disease
- ☐ YES ☐ NO Blood Transfusion
- ☐ YES ☐ NO Breathing Problem
- ☐ YES ☐ NO Bruise Easily
- ☐ YES ☐ NO Cancer
- ☐ YES ☐ NO Chemotherapy
- ☐ YES ☐ NO Chest Pains
- ☐ YES ☐ NO Cold Sores/Fever Blisters
- ☐ YES ☐ NO Congenital Heart Disorder
- ☐ YES ☐ NO Convulsions
- ☐ YES ☐ NO Cortisone Medicine
- ☐ YES ☐ NO Diabetes
- ☐ YES ☐ NO Drug Addiction
- ☐ YES ☐ NO Easily Winded
- ☐ YES ☐ NO Emphysema
- ☐ YES ☐ NO Epilepsy or Seizures
- ☐ YES ☐ NO Excessive Bleeding
- ☐ YES ☐ NO Excessive Thirst
- ☐ YES ☐ NO Fainting Spells/Dizziness
- ☐ YES ☐ NO Frequent Cough
- ☐ YES ☐ NO Frequent Diarrhea
- ☐ YES ☐ NO Frequent Headaches
- ☐ YES ☐ NO Genital Herpes
- ☐ YES ☐ NO Glaucoma
- ☐ YES ☐ NO Hay fever
- ☐ YES ☐ NO Heart Attack/ Failure
- ☐ YES ☐ NO Heart Murmur
- ☐ YES ☐ NO Heart Pacemaker
- ☐ YES ☐ NO Heart Trouble
- ☐ YES ☐ NO Hemophilia
- ☐ YES ☐ NO Hepatitis A
- ☐ YES ☐ NO Hepatitis B or C
- ☐ YES ☐ NO Herpes
- ☐ YES ☐ NO High Blood Pressure
- ☐ YES ☐ NO High Cholesterol
- ☐ YES ☐ NO Hives or Rash
- ☐ YES ☐ NO Hypoglycemia
- ☐ YES ☐ NO Irregular Heartbeat
- ☐ YES ☐ NO Kidney Problems
- ☐ YES ☐ NO Leukemia
- ☐ YES ☐ NO Liver Disease
- ☐ YES ☐ NO Low Blood Pressure
- ☐ YES ☐ NO Lung Disease
- ☐ YES ☐ NO Mitral Valve Prolapse
- ☐ YES ☐ NO Osteoporosis
- ☐ YES ☐ NO Pain in Jaw Joints
- ☐ YES ☐ NO Parathyroid Disease
- ☐ YES ☐ NO Psychiatric Care
- ☐ YES ☐ NO Radiation Treatments
- ☐ YES ☐ NO Renal Dialysis
- ☐ YES ☐ NO Rheumatism
- ☐ YES ☐ NO Scarlet Fever
- ☐ YES ☐ NO Shingles
- ☐ YES ☐ NO Sickle Cell Disease
- ☐ YES ☐ NO Sinus Trouble
- ☐ YES ☐ NO Spina Bifida
- ☐ YES ☐ NO Stomach/Intestinal Disease
- ☐ YES ☐ NO Stroke
- ☐ YES ☐ NO Swelling of Limbs
- ☐ YES ☐ NO Thyroid Disease
- ☐ YES ☐ NO Tonsillitis
- ☐ YES ☐ NO Tuberculosis
- ☐ YES ☐ NO Tumors or Growths
- ☐ YES ☐ NO Ulcers
- ☐ YES ☐ NO Venereal Disease
- ☐ YES ☐ NO Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ YES ☐ NO specify*:* _____

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.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Dental History

Have you ever had any complications following dental treatment? Yes /No If yes, please explain:_____

_____

How long since you have seen a dentist? _____ Last Cleaning: _____

Are you having problems now? -Yes ☐ No ☐

If so what? _____

Do you have missing teeth? -Yes ☐ No ☐

Are you interested in dental Implants? - Yes ☐ No ☐

Would you like a cosmetic consultation? - Yes ☐ No ☐

If so, circle what interests you; Invisalign, Veneer, other options: _____

Have you worn braces on your teeth? (Orthodontics) - Yes ☐ No ☐

Are your teeth sensitive to hot/cold pressure? (Circle) -Yes ☐ No ☐

Do you have headaches, earaches or neck pains? - Yes ☐ No ☐

Please rank the following reasons you might avoid dental treatment; (1 most important, 4 being least)

Fear of Pain _____ Lack of Concern_____ Cost _____ Missing Work _____

Have you had any periodontal (gum) treatments? - Yes ☐ No ☐

Have you experienced any of the following?

Bleeding Gums ___ Inflamed Gums ___ Gum Pain ___ Gum Recession ___ Tooth Mobility ___ Bad Taste/Bad Breath ___

Any other comments:

_____

_____

Patient Name: _____ Date:_____

Consent for Services

The undersigned hereby authorizes the doctor to take X-rays, study models, photographs or any other diagnosis aids deemed appropriate by the doctor to make a complete examination and diagnosis of the patient's needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I understand that the use of anesthetic agents embodies certain risks. I understand that my treatment plan may vary during the course of treatment due to new clinical findings. As a condition of your treatment by this office, financial arrangements are discussed in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services are financial their responsibility. Insurance serves as a method of payment and does not guarantee payment; therefore it is ultimately the patients' responsibility. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Patient Name & Signature

NOTICE OF PRIVACY PRACTICES

Smiles by Design
John M Garcia D.D.S.
4450 Weston Road
Weston, FL. 33331
954-217-1411 f: 954-217-7714
www.yourwestondentist.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills
or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some
may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES
By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS
If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION
If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

I acknowledge that I received a copy of Dr. John M. Garcia DDS Notice of Privacy Practices.

Patient Name: _____ Date: _____

Signature: _____ Relationship: _____

Financial Policy

Thank you for choosing Smiles By Design, Inc. Our primary mission is to deliver the finest and most comprehensive dental care available. An important part of the mission is making cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- Payment Plans available
- Convenient Monthly, Payment Options from Care Credit Healthcare Credit Card
    - Flexible financing options
    - 0% interest finance options
    - Allow you to pay over time
    - No annual fee or pre-payment penalties
- We offer a 10% courtesy accounting adjustment to patients who pre-pay their treatment in cash for qualifying amounts and treatment. (this option is case by case)

Please note:

Smiles By Design, Inc. requires payment prior to the completion of you treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

Cancellation & No-Show Policy

If you are cannot make it to your scheduled appointment, please notify the office within **24 hours**. There will be a minimum charge of $50 for a broken appointment or cancellation with **less than 24 hours'** notice of your appointment.

Insurance:

For patients with dental insurance we are happy to work with your carrier to maximize your benefit. However, the patient is still responsible for the full fee of the treatment. Pre-determinations prior to treatment can be requested. Ask our office staff for more information.

Return Checks: Smiles By Design, Inc. charges $30 for returned checks.

If you have any questions, please do not hesitate to ask, we are here to help you.

Signature: _____ Date:_____

Print Name: _____ Relationship: _____

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home. Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

Signature: _____ Date:_____

Print Name: _____ Relationship: _____

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Sleep Assessment

Patient name:_____ **Date**:_____

Do you feel **tired** during the day?_____

Do you **snore** or have you been told you snore? _____

Have you had a **sleep study** or been told to get a sleep study?_____
Approximate year of last **sleep study** (if applicable)?_____

Have you been **diagnosed** with sleep apnea?_____

Do you currently wear a **C-PAP** or have you in the past?_____

If yes, **how often** are you using your **C-PAP**?_____

If no, have you been told to?_____

Do you currently wear any type of **dental device** to help with your sleep apnea?_____

---------**Please do not write below this line. Healthcare provider section**---------

Notes:_____
_____
_____
_____
_____
_____
_____

Provider signature:_____