

PATIENT REGISTRATION

ID: _____ Chart ID: _____
 First Name: _____ Last Name: _____ Middle Initial: _____
 Patient Is: Policy Holder Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name:	Last Name:	Middle Initial:
Address:	Address 2:	
City, State, Zip:		Pager:
Home Phone:	Work Phone:	Ext:
		Cellular:
Birth Date:	Soc Sec:	Drivers Lic:
<input type="checkbox"/> Responsible Party is also a Policy Holder for Patient <input type="checkbox"/> Primary Insurance Policy Holder <input type="checkbox"/> Secondary Insurance Policy Holder		

Patient Information

Address:	Address 2:	Pager:
City:	State / Zip:	
Home Phone:	Work Phone:	Ext:
		Cellular:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Birth Date:	Age:	Soc Sec:
		Drivers Lic:
E-mail:	<input type="checkbox"/> I would like to receive correspondences via e-mail.	

Section 2

Section 3

Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Medicaid ID: _____ Employer ID: _____ Carrier ID: _____	Emergency Contact _____ Emergency # _____ Pref. Dentist: _____ Pref. Pharmacy: _____ Pref. Hyg: _____
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Primary Insurance Information

Name of Insured:	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec:	Insured Birth Date:
Employer:	Ins. Company:
Address:	Address:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:
Rem. Benefits:	Rem. Deduct:

Secondary Insurance Information

Name of Insured:	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec:	Insured Birth Date:
Employer:	Ins. Company:
Address:	Address:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:
Rem. Benefits:	Rem. Deduct:

Marilyn Amaral, D.D.S.
Eaglesoft Medical History

Patient Name: _____

Birth Date: _____

Date Created: _____

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 _____
- Have you ever been hospitalized or had a major operation? Yes No If yes _____
- Have you ever had a serious head or neck injury? Yes No If yes _____
- Are you taking any medications, pills, or drugs? Yes No If yes _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No

Women: Are you...

- Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes _____

Do you use controlled substances? Yes No If yes _____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed Yes No If yes _____

Comments:

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: _____

X

Date: _____

FOREVERS TILE

Marilyn Amaral D.D.S.

NOTICE OF PRIVACY PRACTICES

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14 2003 and will remain in effect until we replace it.

We reserve the right to change our policy practices and the terms of this Notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make significant change in our privacy practices we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose your health information about you for treatment payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition or death, if you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES.

You may refuse to sign the acknowledgement

I _____ have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office use only

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

Marilyn Amaral, D.D.S. P.A.
General and Cosmetic Dentistry
FOREVERS FILE

Date: _____

PATIENT RESPONSIBILITY

I _____ acknowledge that if my Insurance does not cover my treatment, I will be responsible for the payment to DR. Marilyn Amaral.

- I also will be responsible for all my co-payment and deductibles.
- If I do not have dental insurance, I will pay for my dental work in full on my Date of Service.

CANCELLATION:

If I'm going to cancel my appointment, I will do so with at least 48 hours of anticipation. If I do not cancel my appointment within 48 hours' notice, or do not show to my dental appointment, I will be charged a fee of \$50.00 per hour of treatment time after the third missed appointment with less than a 48hour notice.

Patient Signature

Parent Guardian

X-Ray Patient Consent Form

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself which Dr. Amaral considers necessary in the course of my examination and treatment.

Patient Signature

Parent Guardian

If Patient is a Minor

I am the parent or legal guardian representative of _____ who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray of this minor which Dr. Amaral considers necessary.

Patient Signature

Parent Guardian

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and Dr. Amaral has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to and unborn child.

Patient Signature

Parent Guardian

FOREVERS FILE

Marilyn Amaral D.D.S.

Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment options:

1. Cash
2. Check
3. MasterCard
4. Visa
5. Discover
6. Care Credit
7. Credit card authorization for recurring charges:
 - a. Treatment exceeds \$200
 - b. Plan may not exceed 4 months

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion (downgrade between composites (white fillings) amalgam's (silver fillings), procedures and/or deductibles at the time of the service, **OR** the patient can sign a credit card authorization to bill their credit card **AFTER** insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make **PRIOR** arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.

There is a \$30.00 processing charge for **non-sufficient funds** or returned checks.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **\$25 - \$50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 HOURS IN ADVANCE.**

I, _____, agree to these financial terms.

Signature _____ Date _____

MARILYN AMARAL D.D.S. P.A.

GENERAL AND COSMETIC DENTISTRY

FOREVERS FILE

PICTURE CONSENT FORM

I _____ allow Dr. Marilyn Amaral to display my treatment before and after pictures. Illustrating only my smile, it will not show my face unless otherwise specified. If shown it will exclusively be only in office and on our company's website and social networks.

Signature

Date

Consent for Internet Communications

First Name: _____ Last Name: _____ MI: _____

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice **CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.**

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature of patient

Parent, or guardian signature

Date

Marilyn Amaral, D.D.S

GENERAL AND COSMETIC DENTISTRY

Oral Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient. One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Studies also suggest that human papillomavirus (HPV) plays a role in more than 20% of oral cancer causes.*

Oral cancer risks by patient profile are as follows:

Increased risk: patients ages 18-39; sexually active patients (HPV)

High risk: patients age 40 and older; tobacco users (ages 18-39, any type within 10 years)

Highest risk: patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated VELscope (Visually Enhanced Lesion scope) into our oral screening standard of care. We find that using VELscope along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope, along with the doctor's visual exam, is similar to other proven early cancer detection procedures, such as mammogram, Pap smear, and PSA test. VELscope is a simple and painless examination that gives the best chance to find any abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The VELscope exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is \$25.00.

- Yes. I would prefer to have the VELscope exam at this time.
 No. I would prefer not to have the VELscope exam at this time.

Print Name _____

Signature _____ Date _____



Getting To Know You

If you could wave a magic wand and change one thing about your smile, what would it be?

If there were a simple, inexpensive way to whiten your teeth would you be interested?

YES__ NO__

Why did you leave your last dentist?

What did you like best about your last dentist?

What did you like least about your last dentist?
