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:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ 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:

HISTORIA MÉDICA

Nombre del paciente:______________________________

Fecha de nacimiento:____________________

Aunque el personal dental principalmente tratan el área y alrededor de su boca, su boca es una parte de su cuerpo. Los problemas de salud que pueda tener, o medicamentos que esté tomando, podrían tener una importante relación con la odontología que usted recibirá. Gracias por contestar las siguientes preguntas.

¿Está usted bajo el cuidado de un médico ahora? ☐Sí ☐No En caso afirmativo, sírvase explicar:______________________

¿Alguna vez ha sido hospitalizado o tenido una operación mayor? ☐Sí ☐No En caso afirmativo, sírvase explicar:______________________

¿Ha tenido alguna vez una lesión grave en la cabeza o en el cuello? ☐Sí ☐No En caso afirmativo, sírvase explicar:______________________

¿Está usted tomando algún medicamento, pastillas, o drogas? ☐Sí ☐No En caso afirmativo, sírvase explicar:______________________

¿Toma o ha tomado, Phen-Fen o Redux? ☐Sí ☐No

Alguna vez a tomado Fosamax, Boniva, Actonel,o cualquier otro medicamento que contenga bifosfonatos? ☐Sí ☐No

Esta usted en una dieta especial? ☐Sí ☐No

¿Usa tabaco? ☐Sí ☐No

¿Usted usa sustancias controladas? ☐Sí ☐No

Mujeres: ¿Está usted

Embarazada o tratando de quedar embarazada? ☐Sí ☐No Toma anticonceptivos orales? ☐Sí ☐No Esta amamantando? ☐Sí ☐No

Es usted alérgico a cualquiera de los siguiente?

☐Aspirina ☐Penicilina ☐Codeína ☐Acrílico ☐Metálico ☐Látex ☐Anestésicos locales Sulfamida

☐Otros En caso afirmativo, sírvase explicar:______________________

¿Tiene, o ha tenido, cualquiera de los siguientes?

SIDA / HIV Positivo	☐Sí ☐No	Cortisona	☐Sí ☐No	Hemofilia	☐Sí ☐No	Tratamiento con radiación	☐Sí ☐No
Enfermedad de Alzheimer's	☐Sí ☐No	Diabetes	☐Sí ☐No	Hepatitis A	☐Sí ☐No	Pérdida de peso reciente	☐Sí ☐No
Anafilaxia	☐Sí ☐No	Drogadicción	☐Sí ☐No	Hepatitis B o C	☐Sí ☐No	Diálisis renal	☐Sí ☐No
Anemia	☐Sí ☐No	Fácilmente pierde el aliento	☐Sí ☐No	Herpes	☐Sí ☐No	Fiebre reumática	☐Sí ☐No
Angina	☐Sí ☐No	Enfisema	☐Sí ☐No	Presión arterial alta	☐Sí ☐No	Reumatismo	☐Sí ☐No
Artritis/Gota	☐Sí ☐No	Epilepsia o convulsiones	☐Sí ☐No	Colesterol Alto	☐Sí ☐No	Escarlatina	☐Sí ☐No
Válvula del corazón artificial	☐Sí ☐No	Sangrado excesivo	☐Sí ☐No	Ronchas o erupción cutánea	☐Sí ☐No	Herpes	☐Sí ☐No
Articulación artificial	☐Sí ☐No	Sed excesiva	☐Sí ☐No	Hipoglucemia	☐Sí ☐No	Enfermedad de células falciformes	☐Sí ☐No
Asma	☐Sí ☐No	Desmayos / vértigo	☐Sí ☐No	Latido irregular del corazón	☐Sí ☐No	Problemas del seno nasal	☐Sí ☐No
Enfermedad arterial	☐Sí ☐No	Tos frecuente	☐Sí ☐No	Problemas de los riñones	☐Sí ☐No	Espina Bífida	☐Sí ☐No
Transfusión de sangre	☐Sí ☐No	Diarrea frecuente	☐Sí ☐No	Leucemia	☐Sí ☐No	Enfermedad estomacal/intestinal	☐Sí ☐No
Problemas respiratorio	☐Sí ☐No	Dolores de cabeza frecuente	☐Sí ☐No	Enfermedades del Hígado	☐Sí ☐No	Ataque fulminante	☐Sí ☐No
Cáncer	☐Sí ☐No	Glaucomas	☐Sí ☐No	Presión arterial baja	☐Sí ☐No	Hinchazón de las extremidades	☐Sí ☐No
Moretonescon facilidad	☐Sí ☐No	Herpes Genital	☐Sí ☐No	Enfermedad pulmonar	☐Sí ☐No	Enfermedad de la Tiroides	☐Sí ☐No
Quimioterapia	☐Sí ☐No	Fiebre del heno	☐Sí ☐No	Prolapso de la válvula mitral	☐Sí ☐No	Amigdalitis	☐Sí ☐No
Dolores en el pecho	☐Sí ☐No	Ataque/Falla del corazón	☐Sí ☐No	Osteoporosis	☐Sí ☐No	Tuberculosis	☐Sí ☐No
Herpes labial/Fiebre Ampollas	☐Sí ☐No	Soplo cardíaco	☐Sí ☐No	Dolor en la articulacion de la quijada	☐Sí ☐No	Tumores o crecimientos	☐Sí ☐No
Cardiopatía congénita	☐Sí ☐No	Marcapasos en el Corazón	☐Sí ☐No	Enfermedad paratiroidea	☐Sí ☐No	Úlceras	☐Sí ☐No
Convulsiones	☐Sí ☐No	Problemas/Enfermedad del corazón	☐Sí ☐No	Atención Psiquiátrica	☐Sí ☐No	Enfermedad venérea	☐Sí ☐No
						La ictericia amarilla	☐Sí ☐No

¿Ha tenido alguna enfermedad grave que no figura en la lista de arriba? ☐Sí ☐No En caso afirmativo, sírvase explicar:______________________

Comentarios: ____

En lo mejor de mi conocimiento, las preguntas de este cuestionario se han contestado correctamente. Entiendo que el proporcionar información incorrecta puede ser peligroso para mi salud (o del paciente). Es mi responsabilidad informar a la oficina dental de cualquier cambio en el estado médico.

Firma del paciente, padre o tutor______________________________ Fecha__________________

FOREVERS ILE

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 ILE

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 ILE

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 ILE

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 ______________

*U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, NIDCR, NIH, 2000

Marilyn Amaral, D.D.S. P.A.
General and Cosmetic Dentistry
FOREVERS⁻ ⁀ILE

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?

____

____

____