El Paseo Dental Care

Dental Appointment Agreement

It is important for patients to keep their dental appointments, because broken appointments result in lost time that could have been used to treat other patients.

Rescheduling Appointments

Our office understands that sometimes situations arise that require rescheduling of your dental appointment. **If you need to reschedule, please call the dental clinic as soon as you know that you will not be able to keep the appointment, preferably at least 24 hours before the appointment time.**

Broken Appointments

If you miss a scheduled appointment or cancel it at the last minute, a broken appointment will be recorded in your dental chart. If you are more than 10 minutes late for an appointment, a broken appointment will also be recorded, and you may have to be rescheduled if there is not enough time to complete your procedure.

We try very hard to maintain our schedule so that all our patients can be treated promptly. Needless to say, canceling with short notice, showing up late, or simply not showing up is very disruptive for our schedule and unfair for our other patients who value prompt treatment.

Failure to keep your appointments or cancelling without **24 hour notice** will result in you the patient (or Guardian) being charged a **$95 per hour** for the missed appointment.

I understand the Dental Appointment Agreement and agree to follow the terms of the broken appointment policy.

_____

Patient Name (please print) Date

_____

Patient or Guardian Signature

El Paseo Dental Care

INFORMED CONSENT FOR TREATMENT

I understand that by initialing and signing below, I am requesting and authorizing the procedure(s) to be performed and I have read and understand the possible risks and complications of the procedure(s).

I understand that I am having the following dental procedures completed today:

X-rays & Photographs: (Taking of intra-oral and extra-oral radiographs). Benefits of treatment: taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. X-rays and photos are also necessary for proper diagnosis and evaluation purposes. Alternatives of treatment: **none;** limited visual examination. Common risks: radiation exposure to soft and hard tissues. Consequences of not performing the treatment: missed diagnosis. **Initial: _____**

Prophylaxis: Today I will be receiving a professional prophylaxis (cleaning) by a Registered Dental Hygienist. Dental cleanings are essential for maintaining health in your mouth. Overtime, bacteria, food debris, and calcified (hardened) material can accumulate on your teeth that your tooth brush cannot remove. Some people get this accumulation much quicker and in greater amounts than others. It may be recommended that you receive professional cleaning every 3, 4, 6 or 12 months depending on your level of need. **Risks:** Teeth may become sensitive to air, hot or cold stimuli, TMJ (Jaw Joint) may become tender due to prolonged mouth opening, & tenderness may be present in the gums for a short time after a cleaning. **Initial:** _____

Treatment Plan Estimates: I understand that fees quoted to me for treatment are only an estimate and subject to modification depending upon unforeseen or un-diagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have that I am responsible for payment of any and all dental treatment rendered. There has been no guarantee or assurance made by anyone in regard to the dental treatment I am authorizing**. Initials: _____**

NOTICE: By signing this agreement, you are agreeing to have any issue of fees, treatment, or alleged malpractice decided by a binding neutral arbitration, and you are giving up your right to a jury or court trial.

Print Name: _____

Signature: _____

Today's Date: _____

Witness:_____

EL PASEO DENTAL CARE
Patient Information

Patient Name: _____ **Date of Birth:**_____

Preferred: _____ **Male:** _____ **Female:** _____ **Single:** ____ **Married:** ____ **Child:** ____

Parent/Guardian if patient is a child: _____ **Patient SS#** _____

Home Address: _____**City:**_____ **State:**_____ **Zip:**_____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Employer:** _____

Email Address: _____ **Best time to call:** _____

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

Medical History Update

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐Y ☐ N Under a physician's care now?

☐Y ☐N Any hospitalization in the past 5 years? .....

☐Y ☐ N Any serious illnesses/surgeries? .....

☐Y ☐ N Use tobacco in any form? If Yes, Type: .....

☐Y ☐ N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ☐Y ☐N Currently nursing? ☐Y ☐N Currently pregnant? Due Date: .....

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Y ☐ N
If yes, please describe:

.....

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe:

.....

Dental Insurance Information

Name of Primary Insurance: _____Group #:_____

Subscribers Name: _____Subscribers DOB:_____

Subscribers SS# or Ins ID#_____ Employer: _____

ALLERGIES/ALLERGIC REACTIONS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

- ☐ ASPIRIN
- ☐ ANESTHETIC – LOCAL
- ☐ BARBITURATES
- ☐ CODEINE
- ☐ DAIRY
- ☐ LATEX
- ☐ LACTOSE INTOLERANCE
- ☐ METAL SENSITIVITY
- ☐ NITROUS OXIDE SEDATION
- ☐ SLEEPING PILLS
- ☐ SULFA DRUGS
- ☐ PENICILLIN/OTHER ANTIBIOTICS
- ☐ NONE

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

- ☐ ACID REFLUX
- ☐ ADHD
- ☐ AIDS/HIV
- ☐ ANEMIA
- ☐ ANOREXIA
- ☐ ANXIETY
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ AUTISM/ASPERGER'S
- ☐ BLEEDING DISORDER
- ☐ BULIMIA
- ☐ CANCER/MALIGNANCY
- ☐ CEREBRAL PALSY
- ☐ CHEMICAL DEPENDENCY
- ☐ CHICKEN POX
- ☐ CONVULSIONS
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIZZINESS/FAINTING
- ☐ EPILEPSY/SEIZURES
- ☐ FREQUENT EAR INFECTIONS
- ☐ FREQUENT HEADACHES
- ☐ HEARING PROBLEMS
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER PROBLEMS
- ☐ MITRAL VALVE PROLAPSE
- ☐ MONONUCLEOSIS
- ☐ PACEMAKER
- ☐ OTHER – PLEASE LIST: _____
- ☐ PSYCHIATRIC TREATMENT
- ☐ RADIATION/CHEMO
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SINUS PROBLEMS
- ☐ STROKE
- ☐ THYROID CONDITION
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ VENEREAL DISEASE

☐ OTHER – PLEASE LIST _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

- ☐ ANTIBIOTICS/SULFA DRUGS
- ☐ BLOOD THINNERS
- ☐ INSULIN
- ☐ RECREATIONAL DRUGS
- ☐ OTC DRUGS/ MEDICATIONS (PLEASE LIST BELOW)
- ☐ ANTIHISTAMINES/ALLERGY
- ☐ CANCER/CHEMO MEDICATIONS
- ☐ NITROGLYCERIN
- ☐ THYROID MEDICATIONS
- ☐ OTHER (PLEASE LIST BELOW)
- ☐ DAILY ASPIRIN
- ☐ CORTISONE/STEROIDS
- ☐ ORAL CONTRACEPTIVES
- ☐ TRANQUILIZERS
- ☐ BLOOD PRESSURE MEDICATIONS
- ☐ HEART MEDICATION/DIGITALIS
- ☐ OSTEOPOROSIS MEDICATIONS
- ☐ OTHER DIABETIC MEDICATIONS

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: _____ DATE: _____

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

El Paseo Dental Care

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the must current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date Signed: _____

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____