Dental Art Designs
Juana Geldres, DDS, PA.

1911 Forest Hill Blvd, West Palm Beach, FL 33406 ☎ (561)-439-7400 🖷 (561)-439-7443 ✉ juanageldresdds@live.com

PATIENT INFORMATION

Patient Name: _____ Date _____

Address: _____City: _____State: _____ Zip Code: _____

Sex: **F M** Marital Status: **Single Married Widow Divorced** SS# _____ DOB:_____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

Email: _____@_____

INFORMATION OF RESPONSIBLE PERSON

If any other than the Patient: Relationship to Minor/Patient:_____

Patient's Name: _____ Date _____

Address: _____City: _____ State: _____ Zip Code: _____

SS # _____ DOB: _____ Cell Phone: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

Patient Friend Yellow Pages Radio Website Other

HIPPA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT TO LEAVE MESSAGE

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

Patient's Signature _____Date: _____

If you are a legal representative of the patient, please print the patient's name and describe your authority_____

_____. You may request a copy of our Notice at any time.

We must disclose your health information to you, and we may disclose to a family member, friend or other person to extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

I wish to be called at home ___; Cell Phone ___; Other ___ (Check all that apply) regarding my care and follow up. The best number to reach me are: _____ Home _____Other

I do ___, I do not ___ give permission to leave relevant medical information on my answering machine or voice mail. The name(s) of the individual(s) with whom you may leave pertinent information are: _____

_____

I do __, I do not __ want relevant medical information shared with the person who may answer the phone. The name(s) of the individual(s) with whom you may leave pertinent information are: _____

_____

Patient's Signature _____Date: _____

Office use ONLY – As privacy officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

____ It was an emergency treatment ____ I could not communicate with the patient. ____ The patient refuses to sign.
____ The patient was unable to sign because: _____
____ Other

Signature of Private Officer: _____

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Patient Name:_____ Date _____/_____/_____

MEDICAL HISTORY **(Please Circle YES or NO)**

1. Has there been a recent change in your health?.....YES NO
   If yes, please explain: _____
2. When was your last physical examination? _____
3. Are you under the care of a physician? ..... YES NO
   If yes, condition: _____
4. Have you been hospitalized or had a serious illness within the last 5 years? ..... YES NO
   If yes, what was the problem: _____
5. Do you have or have you had any of the following (Circle all that apply)?

Artificial Limb or Heart Valve	Arthritis or Rheumatism	Hepatitis or Liver Disease
Organ Transplant	Heart attack / Stroke	Psychiatric/Emotional Disorder
Asthma or COPD	Kidney Problems	HIV and/or AIDS
Fainting Spells or Seizures	Sexually Transmitted Disease	Controlled Substance or Alcohol
Tuberculosis	Pacemaker	Diabetes Type I or Type II
Abnormal Bleeding or Blood Disorders	Radiation Therapy	High / Low Blood Pressure
Autoimmune disease	Lupus	Glaucoma
Gastroesophageal reflux disease (GERD)	Thyroid Problem	High Cholesterol

   Other _____
6. Do you have any difficulty breathing through your nose? ..... YES NO
7. Are you currently taking any medication ..... YES NO
   If yes, please list: _____
   _____
8. Are you allergic or do you have addictions to any drugs or medications (i.e. Penicillin, Codeine, Cocaine, Alcohol)? ..... YES NO
   If yes, please list: _____
   _____
9. Are you aware of any lumps in your mouth? ..... YES NO
10. Have you ever had a bad reaction to local or general anesthetic? ..... YES NO
11. Have you ever had excessive bleeding after tooth extraction? ..... YES NO
12. Do you have any disease, condition, or other problems not listed above that you think I should know about? ..... YES NO
    If yes, please describe: _____
13. Do you wish to discuss your medical history privately with the doctor? ..... YES NO
14. Physician's Name: _____ Phone: _____

WOMAN ONLY

1. Are you Pregnant? If so, how many months? ..... YES NO
2. Are you taking birth control pills? ..... YES NO
3. Are you breast feeding? ..... YES NO

DENTAL HISTORY

1. What concerns you most about your teeth? _____
2. Are you aware of any dental problems at this time? _____
3. When was your last dental visit? _____
4. When was the last time you had X-rays taken in a dental office? _____
5. When was your last dental cleaning? _____
6. Have you had any of the following treatments? Orthodontics (Braces), Endodontics (Root Canal), Periodontics (Gum Therapy)? ..... YES NO
   If yes, please specify _____
7. Do you experience pain or clicking in your jaw, ear, or facial muscles upon opening your mouth? ..... YES NO
8. Are you aware of grinding or clenching your teeth? ..... YES NO
9. Do your gums bleed? ..... YES NO
10. Do you suffer anxiety or gagging during dental procedures? ..... YES NO
11. Do you or have you worn partials or dentures? ..... YES NO
12. Do you want to avoid dentures? ..... YES NO
13. Are you unhappy with the appearance of your teeth? .....YES NO
14. What changes would you make about your mouth? _____
15. Interest and Hobbies? _____

PATIENT SIGNATURE _____ **DATE** _____

PARENT or GUARDIAN SIGNATURE (if minor) _____ **DATE** _____

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Dental Treatments, Risk and Alternatives: Your smile is important to us. We offer many procedures that lead to healthy teeth and provide important benefits, such as an alternative smile. You should be aware that dentistry is not an exact science and potential risk and limitations should be considered before undergoing any treatment. Please read the following brief descriptions, benefits, risk and possible complications associated with each treatment. If any of the following procedures is recommended to you by the dentist and you have agreed to receive treatment, an official Informed consent and Agreement will be signed by you, after you have sufficiently informed and have had the opportunity to ask questions and discuss concerns to your satisfaction.

1. **Drugs and Medication**: Antibiotics and analgesics and other medications can cause allergic reactions, causing redness and swelling of tissue, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction.) **Initials** _____

2. **Changes in Treatment Plan:** During treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, in most common, being Root Canal Therapy, with the possible obliteration following routine restorative procedures and crown or an extraction. **Initials** _____

3. **Removal of Teeth:** Every tooth you have is important to you. If alternatives to removal are available, they will be explained to you before the extraction, such as Root Canal Therapy, Crowns, Periodontal Surgery, etc. If the extraction is the treatment of choice (or is necessary as stated in paragraph #3.) You must keep in mind that removing teeth doesn't always remove all the infection, if present, and it may be necessary to have other treatment. Risks involved in having teeth removed are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue (Paresthesia), that can last indefinite or just for a period of time (days or months) or fractured jaw. Therefore, further treatment by specialists or even hospitalization if complications arise during or after treatment is the responsibility of the patient, including the cost. Bisphosphonate patient users have the possibility of osteonecrosis (not healing.) **Initials** _____

4. **Crowns, Bridges and Veneers:** Sometimes it is not possible to match the color of the natural teeth exactly with artificial teeth. In most cases, whitening is recommended prior to procedure. After the teeth are prepared, you will be wearing a temporary crown to protect the tooth or teeth that have been worked on. These may come off easily. After you agree with the color shape, size and comfort of the work, it will be permanently cemented and no esthetic changes will be able to be made. **Initials** _____

5. **Teeth Whitening:** This can produce sensitivity at different levels that varies on each individual and this will gradually go away. It can also cause inflammation of your gums, lips and cheeks if these areas are exposed to the gel. Existing sensitivity, recession, exposed dentin, exposed root surfaces, recently cracked teeth, abfractions (micro-cracks), open cavities, leaking filling or other dental conditions that cause sensitivity or allow penetration of the gel into the tooth may find that those conditions increase or prolong tooth sensitivity or pain after treatment. ZOOM whitening is not recommended for people that are receiving PUVA (Psoraen + Uva) Radiation or other photochemo-therapeutic drugs or treatment as well as patients with Melanoma, Diabetes, or heart conditions. All whitening materials should be avoided by women that are pregnant or lactating. **Initials** _____

6. **Dentures, Complete or Partial:** I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize that final opportunity to make changes in my new dentures (including shape, size, fit placement and color) will be the "Teeth in Wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial replacement. The cost for this procedure is not included in the initial denture fee. **Initials** _____

7. **Endodontic Treatment (Root Canal Therapy):** I understand that there's no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment. Occasionally metal objects are cemented in the tooth or extend through the root, which doesn't necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy or extraction.) **Initials** _____

8. **Periodontal Loss (Tissue and Bone):** This is a serious condition causing gum and bone infection or loss. This can lead to the loss of teeth. Alternative treatment plans will be explained to you, including gum surgery, scaling and Root planning followed by a strict regime of antibiotics and cleaning, replacement and/or extractions. Undertaking any dental procedures may have a future adverse effect on your periodontal condition. **Initials** _____

9. **Implants:** Complications include loss of teeth around the implant site, bleeding, infections, numbness or injury to nearby muscles, nerves or sinus cavity, incomplete healing of the bone around the implant. Smoking and excessive alcohol consumption can influence implant failure. **Initials** _____

10. **Orthodontic:** TMJ problems, periodontal problems, root resorption (root ends are shortened), non-vital or dead tooth, rebound or relapse, decalcification (permanent white/brownish markings.) Total time for treatment can be delayed beyond estimate due to lack of facial growth, poor elastic wear, broken appliances and missed appointments. All factors can affect the quality of the results. Your cooperation and good hygiene is necessary. **Initials**_____

11. **Laser:** Laser for dental treatment (hard and soft tissue and root canal treatment) is a safe and very predictable form of treatment. Laser energy is ***not*** ionizing radiation (i.e. X-rays). Safety glasses are worn to protect eyes from any unforeseen effects. Glasses are specific for the type of laser being used. Herpes infections can occur following a laser treatment. Laser therapy can produce burns. Like any other treatment responses of patients, it depends on the patient's immunologic system response. **Initials** _____

12. **Oral Cancer Screening:** This office offers a painless cancer screening exam that gives a better chance to find any oral abnormalities you may have at an early stage. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. Patients 40 years or older and patients 18-39 combined with either tobacco use, chronic alcohol consumption or Oral HPV infection have an *increased risk*. 25% of oral cancer patients have no lifestyle risk factors. **Initial either "yes" or "no" below.**

    _____ YES, I authorize to be screened ($65) _____ NO, I decline to be screened

Patient's name: _____

Patient's Guardian Name: _____

Date: _____

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Patient Name: _____ Date: _____

FINANCIAL POLICY

It is the policy of this office to help keep your dental health care cost as low as possible. In order to do this, we need to keep our billing cost to a minimum. Please help us in the following ways:

- Always bring your current dental insurance card to the office
- Please notify us at the time of check-in of any changes in insurance, address, phone numbers, etc.
- Please double check your insurance plans as to the participating status of the office. We will not deny care to any patient due to the uncertainty of participation status of the office with your insurance company. Please understand that you are responsible for verifying this information with your insurance.
- If we are not able to verify your insurance at the time that services are rendered we will not deny care, but please understand that you are responsible for the charges that will incur and payments are expected in cash, credit card or Care Credit on the same day the services are rendered unless other arrangements are approved prior to the visit.

We only accept the following as methods of payment

Cash Care Credit Discover MasterCard Visa American Express

NO CHECKS

PAYMENT OPTIONS

Your dental health and smile are important to us. Therefore, we have contracted with many insurances and have payment programs designed to help you.

1. We accept most insurances. We are required by our insurance contract to collect co-pays and/or deductibles at the time services are rendered. Co-pays not paid on the day of the visit will be subject to a $20.00 co-pay processing fee. It is the responsibility of the card holder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the card holder verify coverage limits prior to their appointment date. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance.
2. If you have no insurance, we offer great discounts and promotions that are sure to satisfy your dental needs. In many cases when payment in full can't be made, we can offer an individualized budget agreement. If your bill is paid in full by cash, other discounts may apply.
3. Care Credit is accepted here and we can also help you with the application process. This can help you with the co-payments, deductibles and treatments not covered by your insurance. It can also help you with unexpected dental emergencies and enable you to start treatment immediately. This is good both for insured and not insured patients.

MONTHLY STATEMENTS

If you have a balance on your account, a statement will be sent to you. The balance on the statement is due and payable when statement is issued and will be considered past due in not paid within 15 days. If the account becomes past due, we will take the necessary steps to collect this debt. All accounts sent to the collection agency will be reported to the Credit Bureau and you agree to pay all the collection fees and processing fees that may apply. **There is a fee** for all credit card transactions that are charged back of $45.00 and other fees may apply. If you have concerns or questions, please feel free to discuss them with the doctor or proper staff member to help you.

TRANSFER RECORDS

You will need to personally complete the authorization of records release form. All balances have to be paid before any records are obtained or transferred. There is a charge from $15-$25 for all copies with x-rays and a 48hr notice needs to be given to the office after you have no outstanding balances in the office, this includes, but not limited to, treatment, dental supplies, insurance portions and copy fees.

MISSED APPOINTMENT FEES

You will need to pay a fee for any appointment missed, changed or cancelled without a 24hr notice. **The fees are as follows**:

1. General Dentist: $30 per half hr. / $60 per hr.
2. Hygienist: $30 per half hr. / $60 per hr.
3. Orthodontic TX: $30 per appointment
4. Scaling & Root Planning: $75 per visit
5. Periomaintenance: $50 per visit

Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Initials: _____

After reading and understanding, I request that services to be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make a payment when due and my account becomes delinquent it will be turned over to a collection agency. I am fully responsible to pay all collections costs and processing fees that may apply. I will also be at risk to be dismissed from the practice as a patient.

I have read this Financial Policy as outlined **above** and understand that I am ultimately responsible for the charges incurred by my child/children as their legal guardian.

Signature: _____ **Guardian/Parent Name (if minor)**:_____

Guardian/Parent Signature _____

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Effective Date: April 14, 2003

Notice of Privacy Practices

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 care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentially of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice
Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You
The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment: We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law

- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.