TIME 11:00 AM DATE 8/26/2016

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

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

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:

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

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

Cosmetic & General Dentistry
Fabiola M. Liendo, DDS
5693 Coral Ridge Drive
Coral Springs, FL 33076
PH: (954) 757-6644 **Fax:** (954) 757-6999

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

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.

I acknowledge that I have read or received a copy of the Privacy Practices from Sawgrass Dental Arts.

Patient name_____

Signature _____Date:_____

Sawgrass Dental Arts
Fabiola M. Liendo, DDS.
Cosmetic & General Dentistry
5693 Coral Ridge Dr. | Coral Springs | Florida 33076
TELEPHONE: (954)757-6644 | FAX: (954)757-6999

Dear Patient,

It has always been our contention that your time is valuable. Because of this, we have continuously tried to make our office hours convenient and accessible. Our "No Show" policy is as follows:

- If you do not cancel your appointment 24 hours prior, a fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.
- **We offer Saturday appointments to accommodate the schedule of existing patients. Any dental treatment scheduled for Saturday appointments must be paid in advance. A fee of $50 is charged for patients who miss or cancel Saturday appointments without 24 hour notice.**

We will continue to try to make appointments that work for your schedule. We will continue to call or text and confirm your appointment 24 hours in advance. If you have any problems making your appointment, please let us know at that time, and we will reschedule you.

Patient Name

_____

Signature

_____

Date

Sawgrass Dental Arts

Cosmetic & General Dentistry

5693 Coral Ridge Dr. | Coral Springs | Florida 33076
TELEPHONE: (954)757-6644 | FAX: (954)757-6999

Written Financial Policy

Thank you for choosing Sawgrass Dental Arts. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the 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

  We offer a 10% courtesy accounting adjustment to patients who pay their treatment with cash or check prior to completion of care of treatment plans of $1500 or more
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Sawgrass Dental Arts requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $2000 or more, a 20% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for you treatment. [2]

Sawgrass Dental Arts charges $45 for returned checks. Sawgrass Dental Arts does not accept postdated checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier

Sawgrass Dental Arts
Cosmetic & General Dentistry
Fabiola M. Liendo, DDS.

How would you like us to contact you?

Patient's rights of disclosure: In general, the HIPPA privacy rule gives the right to request restrictions on uses and disclosures of health information. The individual is also provided the right to request confidential communications of health information made by alternative means.

Please check off the appropriate mode of communication for your detailed medical information, and circle which mode is the best way to reach you.

I _____(patient's first and last name) wish to be contacted in the following manner:

(Please circle preferential method of contact)

- **HOME Telephone # _____**
  _____ OK to leave message
  _____ Leave message with call back number only

- **CELL PHONE Telephone #_____**
  _____ OK to leave message
  _____ Leave message with call back number only

- **WORK Telephone #_____**
  _____ OK to leave message
  _____ Leave message with call back number only

- **WRITTEN COMMUNICATION**
  _____OK to mail home
  _____ OK to fax to home FAX #_____
  _____ OK to fax to work FAX #_____

List all persons in your household who, in your absence, may make requests on your behalf, and with whom we may speak to regarding your dental information.

NAME **RELATIONSHIP**

_____
_____
_____
_____
_____

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Sawgrass Dental Arts
Cosmetic & General Dentistry
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Authorization for Release of Dental Record and X-rays

Name of Patient: _____

Patient's DOB_____

Address:_____

City:_____State_____Zip_____

Additional family members to be included:

Name: _____DOB_____

Name_____DOB_____

Name:_____DOB_____

I (print patient or guardian name) _____,

Hereby authorize the release of dental records or Knowledge concerning my dental health to:

Full Dr. Name:_____

Street Address: _____

City:_____

Practice Telephone Number:_____

Signed (patient or guardian signature):_____Date_____

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