torrado DENTAL

Health History Form

Patient Name:_____
Reason for today's visit:_____
Are you in pain?_____Yes /_____No
Physician's Name: _____Telephone Number:_____

Do you require pre-medication? (choose one) Yes / No / Don't Know
Have you ever taken any medications containing bisphosphonates? This includes brands such as Fosomax, Actonol, Didronel, Boniva, Aredia, and Zomets. Yes / No
Do you take any type of blood thinners? (Coumadin, Plavix, etc.) Yes / No
Do you require a lot of anesthesia for dental appointments? Yes / No
Do you smoke? Yes / No If yes, how long? _____

Are you pregnant or a chance of being pregnant? Y / N
Approx due date: Are you nursing? Y / N

Do you take birth control? _____Y / _____N
Do you have or had any of the following? (Please click Y or N for each one)

High/Low Blood Pressure_____Y/_____N
Kidney / Liver Disease_____Y/_____N
Cancer/Tumors_____Y/_____N
Chemo/Radiation_____Y/_____N
Heart Surgery/Pacemaker_____Y/_____N
Respiratory Problems_____Y/_____N
Hepatitis _____Y/_____N
Asthma _____Y/_____N
Heart Attack/Stroke_____Y/_____N
Sinus Problems_____Y/_____N
HIV+/AIDS_____Y/_____N
Leukemia _____Y/_____N
Mitral Valve Prolapse_____Y/_____N
Jaw Problems TMJ/TMD_____Y/_____N
Rheumatic Fever_____Y/_____N
Artificial Valves_____Y/_____N
Heart Murmur_____Y/_____N

Tuberculosis TB_____Y/_____N
Bleeding Problems_____Y/_____N
Diabetes _____Y/_____N
Artificial Joints/Implants_____Y/_____N
Arthritis/Rheumatism_____Y/_____N
Fainting/Seizures/Epilepsy_____Y/_____N
Chemical Dependency_____Y/_____N
Severe/Frequent Headache_____Y/_____N
Thyroid Issues _____Y/_____N
Venereal Disease_____Y/_____N
Psychiatric Care_____Y/_____N
Periodontal Treatment_____Y/_____N
Loose Teeth _____Y/_____N
Bleeding Gums_____Y/_____N
Sores In The Mouth_____Y/_____N
Sensitive Teeth _____Y/_____N

Surgeries_____Y/_____N If Yes, date and type:_____

Other Medical Conditions Not Listed Above:_____

Please list all current medications:_____

_____

_____

Allergies:

Latex_____**Y/**_____**N** **Penicillin**_____**Y/**_____**N** **Sulfa**_____**Y/**_____**N** **Codeine**_____**Y/**_____**N**

Metal_____**Y/**_____**N**

Other:_____

I have provided the above information to the best of my knowledge. I understand that it is my responsibility to inform the office of any changes to my health or medications.

Signature (Patient/Legal Guardian):_____
Date:_____

Signature (Patient/Legal Guardian):_____
Date:_____

TORRADO DENTAL

Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. H.I.P.P.A., the Health Insurance Portability Act requires that all medical providers, insurance companies, and others put in place controls to ensure that your personal medical information is safe.

Torrado Dental requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

PLEASE CLICK

Authorize Un-Authorize

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your information released to family members you must authorize and sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow Torrado Dental to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Torrado Dental to release my laboratory/radiology results and reports to the following individuals.

1._____Relation to Patient:_____Date:_____

2._____Relation to Patient:_____Date:_____

PLEASE CLICK

Authorize Un-Authorize

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of Torrado Dental to leave messages for patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the staff would like to discuss lab or procedure results, or to ask a patient to call the office regarding an issue or concern. At no time will a representative of Torrado Dental discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

PLEASE CLICK

◯ Authorize ◯ Un-Authorize

Signature of Patient or Representative: _____**Date:**_____
Name of Patient or Representative: _____
Relationship to the Patient: _____

TORRADO DENTAL

Cosmetic and Family Dentistry

Office Financial Policy

To maintain the lowest cost of practice operation possible Torrado Dental requires financial arrangements be discussed and accepted prior to beginning any treatment. Torrado Dental offers a variety of payment options including Cash, Check, all major credit cards and third party financing (with credit approval). The following methods of payment arrangement are accepted:

- ✓ Full payment at the time of treatment
- ✓ 50% down payment at start of treatment and remaining 50% due at the final appointment to complete treatment

Dental Insurance

As a preferred provider for many insurance companies we are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. However, we cannot guarantee the benefits received from your insurance company. Any insurance policy is an agreement between you and your insurance company. **Any insurance claims not paid will become the responsibility of the patient.**

Any balance not resolved will be sent to collections and any additional fees associated with collecting the balance will be added to your account.

Appointment Policy

Torrado Dental does require at least a 24 hour notice of a cancellation. Your appointment time has been reserved for you and we strongly encourage all patients to keep their appointments. Any missed or broken appointment without appropriate notice may be subject to a broken appointment fee.

I have read and understand the financial policies at Torrado Dental. My signature below indicates my acceptance of these policies.

Patient/Guardian/Parent Signature: _____Date_____
Patient/Guardian/Parent Name:_____

Relationship to the Patient: _____