Welcome to our office! We appreciate the confidence you place in us to provide your dental services. To assist us in serving you, we ask that you please fill out all of the following forms completely. Please make sure to sign every page at the bottom. The information provided on these forms is extremely important to your dental health. If you have any questions, please do not hesitate to ask. We will be happy to assist you. Thank you for choosing Torrado Dental!

Patient Information

If the patient is under the age of 18, this form must be completed and signed by a parent or legal guardian.

(Please Print Clearly)

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____

Employer/Occupation: _____ Bus. Phone: _____ SS #: _____

Emergency contact name: _____Contact phone #:_____

Emergency contact relationship to you:_____

Name of your medical doctor: _____ Doctor phone #: _____

Preferred Pharmacy (name/location)_____

Pharmacy phone #:_____

Name of previous dentist: _____ Date of last visit to dentist: _____

How did you hear about us?_____ Referred to us by: _____

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

Patient/Legal Guardian Signature:_____ Date:_____

Print Name:_____ Relationship to patient:_____

Patient Medical History

Patient Name:_____Date of Birth:_____

If female, please answer the following:

Are your pregnant? YES_____NO_____ If yes, # of weeks_____

Are you taking birth control pills? YES_____NO_____ Are you nursing? YES_____NO_____

All Patients:

Do you use tobacco? YES_____NO_____ Height:_____Weight:_____

(*Office Use Only: BP_____Heart Rate:_____***)**

Please circle Yes or No for EACH of the following conditions:

Y N	Abnormal Bleeding	Y N	Diabetes Type II	Y N	Kidney Problems
Y N	Allergies	Y N	Dry Mouth/Xerostomia	Y N	Liver Disease
Y N	Alzheimer's Disease	Y N	Eating Disorder	Y N	Low Blood Pressure
Y N	Anemia	Y N	Emphysema	Y N	Mental Illness
Y N	Anxiety Disorders	Y N	Epilepsy/Seizures	Y N	Mitral Valve Prolapse
Y N	Arthritis	Y N	Frequent Headaches	Y N	Organ Transplant
Y N	Artificial Joints	Y N	GERD	Y N	Pacemaker
Y N	Asthma	Y N	Glaucoma	Y N	Pain in Joints/TMJ
Y N	Bisphonates	Y N	HIV/AIDS	Y N	Parkinson's Disease
Y N	Blood Disorder	Y N	Hay Fever	Y N	Pre Medication
Y N	Cancer	Y N	Heart Attack	Y N	Respiratory Disease
Y N	Cancer-Chemotherapy	Y N	Heart Disease	Y N	Rheumatic Fever
Y N	Cancer-Radiation Treatment	Y N	Heart Murmur	Y N	Sinus Problems
Y N	Chemical Dependency	Y N	Heart Surgery	Y N	Stroke
Y N	Congenital Heart Defect	Y N	Heart Valve Replacement	Y N	Thyroid Problems
Y N	Defibrillator	Y N	Hepatitis	Y N	Ulcers
Y N	Diabetes Type I	Y N	High Blood Pressure		

If you have answered yes to any of the above conditions, or have any other medically related information that we should know about, please explain in detail:_____

_____

_____

Do you have any allergies to: (please circle Yes or No for EACH of the following)

Y N	Aspirin	Y N	Erythromycin	Y N	Metals
Y N	Codeine	Y N	Jewelry	Y N	Penicillin
Y N	Dental Anesthetics	Y N	Latex	Y N	Tetracycline

Please list ALL medications you are currently taking and what they are for:_____

_____

_____

Patient/Guardian Signature_____**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 CIRCLE

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 CIRCLE

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 CIRCLE

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 of $25.00.

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: _____