Welcome to our office! We appreciate the confidence you have placed in us to assist with your dental needs. To aid us in serving you, we ask that you fill out all of the following forms **completely**. Please be sure to sign the bottom of each page. For patients under the age of 18, a parent or legal guardian must be present to sign. If you have any questions, please do not hesitate to ask. We are happy to help! Thank you for choosing Torrado Dental.

Patient Information

Patient name:____ Date of birth: ______________________

Sex: _____________ SS #: ____________________________ Marital status: _________________________

If patient is *under the age of 18*, parent/legal guardian name:____

Home address: ___________________________________City:_______________ State: _____ Zip: _________

Billing address (**if different**): ___________________________City:_______________ State: _____ Zip: _________

Check preferred method of contact: ☐ home phone: ____________________ ☐ cell: ____________________

☐ Work phone:___________________________ ☐ E-mail: ___________________________________

Employer/Occupation: _______________________________________

College Student (please circle): *Full-time* *Part-time* Name of institution: _______________________________

Emergency contact name/phone number: ______________________________(_______)_______-__________

Emergency contact relationship to you:__________________________

Dental Insurance Information

Primary dental insurance: ___________________________________

Subscriber name:____________________________________ Subscriber ID: ____________________

Subscriber DOB: ___________________ Subscriber SS#: ___________________

Secondary dental insurance: _________________________________

Subscriber name:____________________________________ Subscriber ID: ____________________

Subscriber DOB: ___________________ Subscriber SS#: ___________________

Name of previous dental office: ______________________________ Date of last dental visit: _____________

How did you hear about us? Referred 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: ____________________

Patient Consent Form

As of April of 2003, new federal requirements regarding privacy of information for health care patients took effect. The Health Insurance Portability and Accountability Act (HIPAA) require 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.

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 HIPAA, 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:______________

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of our offices 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 our office 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

Patient/Legal Guardian Signature:____ **Date**:_____________

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

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to E. Torrado DDS all insurance benefits, if any, and otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurances. I hereby authorize the doctor to release all the information necessary to secure the payments of benefits. I authorize the use of my signature on all insurance submissions. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Appointment Policy

Torrado Dental does require at least a 24 hour notice for any cancellations. 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/Legal Guardian Signature:____

Date: ______________________

NEW PATIENT MEDICAL HISTORY

Patient Name (print):____ Date of Birth:_____________________

Primary care provider:____ Office phone:_____________________

Preferred pharmacy: ____

In the instance we may need to prescribe you any medications, please list your **height**:_________ and **weight**:_____ _lbs

Please circle YES or NO for **EACH** of the following conditions:

Abnormal bleeding	Y	N	Diabetes Type 2	Y	N	Liver Disease	Y	N
Allergies/Hay fever	Y	N	Drug abuse	Y	N	Low Blood Pressure	Y	N
Alzheimer's disease	Y	N	Eating Disorders	Y	N	Mental Illness	Y	N
Anemia	Y	N	Epilepsy/seizures	Y	N	Mitral Valve Prolapse	Y	N
Anxiety	Y	N	Frequent headaches	Y	N	Organ Transplant	Y	N
Artificial Joints	Y	N	GERD	Y	N	Pacemaker	Y	N
Arthritis/Joint pain	Y	N	Glaucoma	Y	N	Parkinson's Disease	Y	N
Asthma	Y	N	HIV/AIDS	Y	N	Pre-medication	Y	N
Bisphosphonates	Y	N	Heart attack	Y	N	Respiratory Disease	Y	N
Blood disorder	Y	N	Heart Disease	Y	N	Rheumatic Fever	Y	N
Cancer	Y	N	Heart Murmur	Y	N	Sinus problems	Y	N
Cancer treatment	Y	N	Heart surgery	Y	N	Stroke	Y	N
Chemical dependency	Y	N	Heart Valve Replacement	Y	N	Thyroid problems	Y	N
Congenital heart defect	Y	N	Hepatitis	Y	N	Ulcers	Y	N
COPD/emphysema	Y	N	High Blood Pressure	Y	N	Using tobacco products	Y	N
Defibrillator	Y	N	High Cholesterol	Y	N	Other (not listed):		
Diabetes Type 1	Y	N	Kidney Disease	Y	N			

Please list **ALL SURGERIES** you have had (ex: hip/knee replacements, stents, etc.):

____

____

Please list **All MEDICATIONS** you are currently taking and what they are for:

____

____

Are you allergic to any of these? Please circle YES or NO for **EACH** of the following:

Aspirin	Y	N	Jewelry	Y	N	Sulfa Drugs	Y	N
Codeine	Y	N	Latex	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Metals	Y	N	Other (please list below↓):		
Erythromycin	Y	N	Penicillin	Y	N			

If **female**, please circle YES or NO to each of the following:

Are you pregnant? If so, how many weeks? Y______ N______ # of weeks: _______

Are you nursing? Y______ N______

Are you taking birth control pills? Y______ N______

Patient/Guardian Signature:____ **Date:** ____________________