Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you have or have you had any of the following?		

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____

PATTERSON OFFICE SUPPLIES 1.800.637.1140 **051-1014**/16306

Elizabeth H. Guerrero D.D.S.
A Professional Corporation
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

phone 275-0666 fax 275-0647

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Elizabeth H. Guerrero D.D.S.
A Professional Corporation
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

DENTAL INSURANCE ASSIGNMENT OF BENEFITS

I authorize Dr. Guerrero to release any/all information including: exams, treatment records, x-rays, and diagnosis. For services rendered to me or my dependents during the period of such dental care, to third party payors and/or other health care providers.

I authorize and request my insurance company to pay directly to Dr. Guerrero, insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature Date

Discrimination is Against the Law

Dr. Elizabeth H. Guerrero
complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Dr. Elizabeth H. Guerrero
does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Dr. Elizabeth H. Guerrero:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

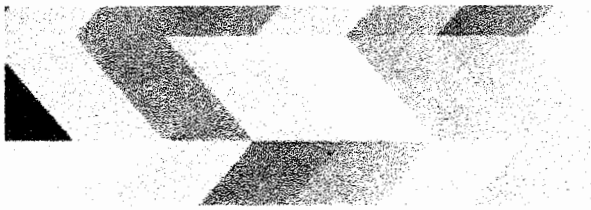
If you need these services, contact Dr. Elizabeth H. Guerrero.

If you believe that Dr. Elizabeth H. Guerrero
has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.



ADA Center for Professional Success™

Louisiana

We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.

Spanish:
Tomaremos acciones razonables para proporcionar servicios de asistencia lingüística gratuitos a aquellas personas cuyo lenguaje escuchemos frecuentemente en nuestro consultorio y que no hablen un inglés lo suficientemente bueno como para hablar con nosotros sobre el servicio odontológico que suministramos.

French:
Nous prendrons les mesures raisonnables pour fournir des services d'assistance linguistique gratuits pour les individus qui parlent des langues que nous sommes susceptibles d'entendre durant nos séances et qui ne parlent pas suffisamment bien l'anglais pour discuter avec nous concernant les soins dentaires que nous fournissons.

Vietnamese:
Chúng tôi sẽ thực hiện các bước cần thiết để cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho những người giao tiếp bằng những ngôn ngữ mà chúng tôi có thể nghe thấy tại phòng khám của mình và cho những người không có đủ trình độ tiếng Anh để thảo luận về dịch vụ chăm sóc nha khoa mà chúng tôi đang cung cấp.

Chinese:
我们将有序地做到提供免费的语言服务使我们能听懂英语不好的人向我们咨询有关牙齿护理

Arabic:
سوف نقوم باتخاذ خطوات معقولة من أجل توفير خدمات المساعدة اللغوية بدون تكلفة للأشخاص الذين يتحدثون لغات أخرى من المرجح أن نستمع إليها خلال ممارستنا والذين لا يتقنون تحدث الإنجليزية بشكل جيد يمكنهم من التحدث إلينا فيما يتعلق برعاية الأسنان التي نقدمها.

Tagalog:
Gagawin namin ang mga makatwirang hakbang para maibigay namin ng walang bayad ang mga tulong na serbisyo sa wika para sa mga taong nagsasalita ng mga wikang karaniwan naming naririnig sa aming pagsasagawa at sa mga hindi bihasa sa pagsasalita ng Ingles na sasangguni sa amin tungkol sa pangangalaga ng ngipin na ibinibigay namin.

Korean:
저희는 적절한 조치를 통하여 언어 지원 서비스를 무료로 제공할 것입니다. 다만, 실제로 저희에게 관심이 있는 언어를 쓰지만 저희 치아 관리 서비스에 대해 의견을 줄 수 있을 만큼 영어로 의사소통이 원활하지 않는 경우로 한정합니다

Portuguese:
Tomaremos medidas razoáveis para prestar serviços de assistência de linguagem livres de encargos para as pessoas que falam línguas que poderemos ouvir na nossa prática e que não falam Inglês bem o suficiente para nos falarem sobre os cuidados odontológicos que estamos a fornecer.

Laotian:
ພວກເຮົາຈະໃຊ້ຂັ້ນຕອນທີ່ເໝາະສົມ
ເພື່ອໃຫ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າແກ່ຄົນຜູ້ທີ່ເວົ້າພາສາທີ່ພວກເຮົາອາດຈະໄດ້ຍິນຢູ່ໃນການຝຶກຊ້ອມຂອງພວກເຮົາ ແລະ ຜູ້ທີ່ບໍ່ເວົ້າພາສາອັງກິດໄດ້ດີພໍ ເພື່ອລົມກັບພວກເຮົາກ່ຽວກັບການບໍລິການຊ່ອງປາກທີ່ພວກເຮົາກຳລັງຈັດໃຫ້.

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Japanese:
実際に練習の中で耳にするく可能性がある言語を話す人々で、弊社が提供している歯科治療について、英語がそれほど上手でない人々に、無償の言語支援サービスを提供するために合理的な措置を講じるつもりです。

Urdu:
ہم ان لوگوں کو جو ہماری پیش کردہ زبان بولتے ہیں لیکن انگریز ی نہیں جانتے اور ہم سے ڈینٹل کیر کے لیے بات کرتے ہیں مفت زبان دانی کی امداد کے لیے معقول اقدام اٹھائیں گے۔

German:
Wir werden angemessene Schritte unternehmen, um denen eine gebührenfreie Sprachunterstützung zu bieten, die Sprachen sprechen, die wir möglicherweise in unserer Praxis hören, die aber kein Englisch sprechen, das gut genug ist, um mit uns über die Zahnpflege zu sprechen, die wir anbieten.

Persian (Farsi):
ما برای ارائه خدمات ترجمه رایگان به افرادی که زبان انگلیسی آنها برای صحبت با ما درباره خدمات مراقب از دندان ارایه شده ما در حد کافی نبوده و به زبان های صحبت می کنند که ما به احتمال زیاد در هنگام کار با آنها سر و کار پیدا می کنیم گام هایی منطقی را بر خواهیم داشت.

Russian:
Мы принимаем необходимые меры, чтобы предоставить бесплатные услуги переводчика для общения на языках, с которыми мы сталкиваемся в нашей практике с клиентами, которые не владеют английским языком достаточно, чтобы обсудить с нами стоматологическое обслуживание, которое мы предоставляем.

Thai:
เราได้ก้าวไปอีกขั้นด้วยการให้บริการผู้ช่วยด้านภาษาโดยไม่มีค่าบริการ ให้กับผู้ที่ไม่สามารถสื่อสารด้วยภาษาอังกฤษเกี่ยวกับการดูแลทันตกรรมที่เราให้บริการได้ดีพอและใช้ภาษาที่เรามักจะได้ยินปอยในศูนย์ทันตกรรมของเรา

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