WELCOME

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

– O V E R –

OVER →

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No		
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No		
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No		
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No		
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No		
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No		
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No		
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No		
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No		
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No		
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No		
Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Patient Consent To Treat

1. **Drugs, Medications, and Anesthesia:**
   I understand that antibiotics, analgesic, and other medications may cause adverse reactions, some of which are, but not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest. I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle of hazardous device while taking medications/or other drugs, until fully recovered from their effects (this includes a period of at least 24 hours after my release from surgery). I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness and/or irritation to the area of injection. I understand that if I select to utilize Nitrous Oxide, Zanax, Valium, or any other sedative, other risks include, but are not limited to: Loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest. I understand that someone needs to drive me home from the dental office after receiving sedation. I also understand that someone needs to watch me closely for a period of 8/10 hours following my dental appointment.
2. **Hygiene and Periodontics**
   I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene maintenance (brushing, flossing) and regular visits. **Periodontics**: I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to the loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements, or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may need to be extracted.
   Removal of teeth: I understand the purpose of the procedure to remove teeth is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if these conditions persist without treatment, my oral condition will continue to worsen with in time. Potential Risks of an extraction include, but not limited to: Post op discomfort, Injury to adjacent teeth, Limitation of opening, Residual root fragments or bone apicules, Bone fractures, Opening of the sinus, and Injury to nerve under lying the teeth.
3. **Fillings:** I have been advised of the need for fillings, composite, to replace tooth structure lost to decay. I understand that with time the filling will need to be replaced due to wearing material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as a root canal, post, core & crown) which would be a separate charge.
4. **Endodontic Treatment:** The doctor has explained to me that there are certain potential risks in the procedure. These include: 1.Inability to completely fill the root canal because the canal is calcified or has a unique curvature. This may require endodontic surgery or extraction of the tooth. 2. Infection that may occur and may continue, requiring further endodontic surgery or extraction. 3. Fracture or breakage of the root or crown portion during or after treatment. 4. Inadvertent breakage of files or instruments within the root canal system that is unable to be retrieved. 5. Perforation of the tooth during treatment. 6. Damage to existing fillings, crowns, or porcelain veneers.

By signing this line, you have read, understood all of the above.

Name_____ **Date** _____

HIPAA Consent Form

Centre for Cosmetic Dentistry
275 Wilmington W. Chester Pike, Suite 111, Chadds Ford, PA
(610)459-5002 ccd@chaddsforddentistry.com

I understand that I have certain right regarding my certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out treatment: (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers (i.e., my insurance company); the day-to-day healthcare operations of your practice.

I also understand that the State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload, and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand that the dental practice cannot and does not assume any responsibility for any use or misuse of patient information or other information transmitted, monitored, stored, uploaded, or received using the website or internet services.

I, _____ acknowledge receipt of HIPAA consent form.

_____

Print name Date

Centre For Cosmetic Dentistry
275 Wilmington West Chester Pike Suite 111 Chaddsford PA 19317

Financial / Appointment Consent form

For _____ (patient name)

We welcome you and your family to Centre For Cosmetic Dentistry, the office of Dr. Maria Barboza, and associates. We look forward to providing you with the most exceptional dental care. To provide you with the most beneficial and comprehensive service and care, we do ask that you review and complete our office and financial policy consent forms. We will gladly discuss your proposed treatment, financial options and any other questions you may have. We strive to keep you informed and involved with your treatment as much as possible.

Dental Insurance

_____ (initials) I / We **DO NOT** have dental insurance

_____ (initials) I / We **DO** have dental insurance (if so, please continue below)

If you have dental insurance, we will file the claims for you, as a complimentary service. We do ask that the correct insurance information be provided at the time of your appointment in order for us to timely file the claim and collect payments. If this information changes, it is the patient's responsibility to update Centre For Cosmetic Dentistry at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Centre For Cosmetic Dentistry. We do accept payments from the dental insurance companies; however, we may or may not be contracted with them. It is a contract between you, your employer and the insurance company.

Centre For Cosmetic Dentistry will provide you with an **ESTIMATE** of your out of pocket expense for any treatment planned by the doctor(s). However, please understand that these are strictly estimates and are **NOT A GUARENTEE** that your insurance company will reimburse us/you according to these estimates. It is possible that we could preauthorize any treatment to verify plan coverage and benefits.

Please note that any difference in payment from your insurance company and your account balance is YOUR responsibility. We emphasize that as dental care providers, our relationship is with you, **NOT** your insurance company. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient and / or account holder.

Payment for services (copay/coinsurance) is due at the time the services are provided.

I / We understand the above paragraph regarding dental insurance, and have had the opportunity to have any questions answered to the best of Centre For Cosmetic Dentistry's ability.

_____Signature of Responsible Party _____Date