CORAL GABLES DENTAL HEALTH CENTER

747 Ponce De Leon Blvd | Suite 401 | Coral Gables | Fl 33134
305.444.8591 www.gables.dental

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 questions or need assistance, please ask us, we will be happy to help.

Date:________________________
Patient #:________________________

Patient Information (Confidential)

Name: ______________________________________ Birth Date: ___________ S.S. #:______________________
Home Phone: ______________ Cell Phone: ________________E-mail: ________________________________
Address: ____________________________________City: ___________State: ______________ Zip:___________
Check Appropiate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's Employer ____ Work Phone: _______________
Business Address:____________________________City: ___________State: _____________ Zip:________________
Spouse or Parent's Name _______________Employer ___________________Work Phone _____________________
If Patient is a Student, Name of School / College ________________City ____________ State _________________
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 _______________________
Driver's License # ____________________ Birthdate __________Financial Institution_________________________
Employer ____ Work Phone ________________________
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured ____ Relationship to Patient _____________________
Birthdate ___________________Social Security # _____________________ Date Employed ___________________
Name of Employer ____ Work Phone _____________________
Address of Employer _________________________ City: _______________ State: _________Zip:_______________
Insurance Company __________________________ Group # ____________ Union or Local #____________________
Ins Co. Address ______________________________ City: _______________ State: _________Zip:_______________
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 ___________________Social Security # _____________________ Date Employed ___________________
Name of Employer ____ Work Phone _____________________
Address of Employer _________________________ City: _______________ State: _________Zip:_______________
Insurance Company __________________________ Group # ____________ Union or Local #___________________
Ins Co. Address _____________________________ City: ________________ State: _________Zip:_______________
How much is your Deductible? _______ How Much Have You Used?_______Max. Annual Benefit ______________

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?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If Yes, what medication(s) are you taking? ____________________________________		
4. Do you use tobacco?	☐	☐
5. Do you use alcohol?	☐	☐
6. Do you use cocaine or other drugs?	☐	☐
7. Do you wear contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (eg. novacaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐
9. Women Only:		
a) Are you pregnant or think you might be pregnant?.	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

10. Do you have or have you had any of the following?

	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	☐	☐	Sexualty Transmitted Disease	☐	☐	Other	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐			

Patient Dental History

	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 on 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?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) 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 had any orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Have you ever had instructions on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

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 diagnostics 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.

I authorize to takes pictures and videos for scientific and marketing purposes. ☐ Yes ☐ No

X ____

Signature of patient or parent if minor

Doctor's Comments ____

____

Signature ______________________ Date ______________________

FINANCIAL POLICY

In an effort to keep fees reasonable, and to continue to provide quality care, we have established a payment policy. By executing this agreement you are agreeing to pay for all services that are received.

Payments: Our administrative Team will work with you to handle your financial needs, however we do require all routine treatment paid in full at the time of the service. If a financial contract is signed, payment is expected on the agreed due date, outlined in the contract. If a payment billing arrangement is made, the balance of your account is due and payable when the statement is issued, and is past due if not paid within 30 days.

Forms of Payments: Cash, Check and Credit Cards are all acceptable forms of payments. We accept MasterCard, Visa, American Express and Discover. In addition, we also offer third party financing, with processing taking only a few minutes. This is especially convenient if you will be having a comprehensive treatment plan.

Insurance: The financial coordinator will help you and your individual needs. If you have insurance benefits, we can provide an ESTIMATE of what your insurance company is expected to pay, but can make no guarantee of estimated coverage. All charges are your responsibility from the date services are rendered.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your debt to a collection agency, you agree to pay additional collection costs incurred from address searches, credit reports or attorney fees which·can possibly equal 50% of the balance due. We may also take the claim to Small Claims Court. You agree to pay any court fees incurred in trying to collect the past due balance.

Returned Checks: There is a fee for any checks returned by the bank. The fee's can range from $25-$40 depending of the amount of the check written. We prefer payment in cash on accounts with a history of a returned check.

Missed Appointment Fee: The second time a patient does not show up for an appointment, or cancels with less than 24 hours notice, we have the right to charge a $20.00 fee. Extenuating circumstances will be considered. This fee must be paid before a new appointment may be made.

Divorce: In case of divorce or ·separation, the party responsible for the account prior to the divorce or separation, remains responsible for the account. After a divorce or separation, the parent authorizing treatment (signing consents) for a child will be the parent responsible for subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is authorizing parent's responsibility to collect from the other parent.

I have read and understand the financial policy outlined above.

______________________________ ______________________________

Patient's Name Responsible Party

______________________________ ______________________________ _____ / _____ / _____

Relationship to Patient Signature Date

PATIENT'S COMUNICATION METHOD

PATIENT'S NAME: ____

HOME PHONE NUMBER:___(________)____

CELL PHONE NUMBER: ___(________)____

WORK PHONE NUMBER:___(________)____

EMAIL ADDRESS:____

To serve you better, we would like for you to select your appointment confirmation preference. Please check the appropriate form of confirmation desired.

☐ HOME PHONE NUMBER

☐ CELL PHONE NUMBER

☐ WORK PHONE NUMBER

☐ TEXT MESSAGE

☐ EMAIL ADDRESS

☐ NONE OF THE ABOVE

PATIENT'S NAME: ____________________

WHAT DO YOU THINK ABOUT YOUR SMILE?

Are you completely satisfied with the cosmetic appearance of your teeth? If not, what concerns do you have?

____

____

Which of the following would you change if it could be done easily and pain free?

- ☐ Teeth Color
- ☐ Tooth Shape
- ☐ Spaces between teeth
- ☐ Alignment of teeth
- ☐ Size of Teeth
- ☐ General overall appearance of smile

HOW DID YOU HEAR ABOUT US?

- ☐ Family or Friend- Name Please: ______________________________
- ☐ Care to Share
- ☐ Social Media - Facebook or Instagram
- ☐ Our Website www.dhc.dental
- ☐ Google
- ☐ Zoc Doc
- ☐ Demandforce
- ☐ Insurance Company
- ☐ Other: ______________________________