Amaury O. Valle, DMD
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Welcome!!!

Thank you for giving us a chance to be the caretaker of your dental health. We hope to enjoy a familiar relationship between you and our healthcare dental team. We will strive to provide you with best possible dental care. To help us achieve this, please fill out this form completely. If you have any questions don't hesitate to ask us for help. Again thank you and we look forward to assisting your smile!

Date: ________________

Name: ______________________________________
Last , First Initial

DOB: __________ SS#: _______________________

Address: ____________________________________

____

Home phone #: _____________ Work: ____________

Cell: ___________________

Email: ______________________________

Please circle: Minor Male Female

Status: Single Married Divorce

Widowed Separated

How did you hear about us? ____________________

Who may we thank for the referring?

____

Other family member seen:

____

Employer: ___________________________________

Address: ____________________________________

EMERGENCY CONTACT

Name: ______________________________________

Relationship: ________________________________

Phone #s: ___________________________________

Insurance

Insurance and Financial Authorization Release:

We will file your insurance claim for you. It is understood all charges connected with AV Dental Care not covered by an Insurance or third party coverage are due and payable within 60 days of services rendered. By signing you agree you have read and fully understand the above language and agree to be personally responsible for any amount due.

I understand should I fail to pay my balance within 90 days of services rendered my delinquent account is subject to a collection agency unless financial arrangements have been made. If the account is referred for collection I will pay AV Dental Care attorney fees, court cost, and/or collection agency fees associated with the collection process.

____

Signature of patient or Parent if minor Date

Financial Responsible Party

Name of person responsible for the account:

____

Relationship to patient: _________________________

DOB: _________ SS#: ________________________

Address: ____________________________________

____

Home Phone #: ______________ Work: ___________

Employer: ___________________________________

Address: ____________________________________

Primary Dental Insurance

Company: ___________________ Phone #:_________

Insured's Name: ______________________________

SS#/ID #: _______________ Group #: ____________

Insured's DOB: _______________________________

Relationship: _________________________________

Insured's Employer: ____________________________

MEDICAL HISTORY

Physician's Name: ________________________

Date last seen: ________ Phone: ____________

Last Dentist seen: __________________________

Date of last dental exam: ___________________

1. Are you under medical treatment now? Y N

2. Have you ever been hospitalized for any surgical or serious illness? Y N

3. Are you taking any medication including non-prescription medicine? Y N

Which?

____

____

4. FOR WOMEN ONLY:

a. Are you pregnant or think you might be? Y N

b. Are you nursing? Y N

c. Are you taking birth control? Y N

5. Do you smoke or us tobacco? Y N

6. Do you us alcohol, cocaine or other drugs? Y N

7. Are you wearing contact lenses? Y N

8. Do you snore? Y N

9. Do you have breathing problems at night during sleep? Y N

10. Are you allergic to or have you had any reactions to the following?

Local Anesthetics	Y	N
Penicillin or other antibiotics	Y	N
Sulfa Drugs	Y	N
Aspirin	Y	N
Latex	Y	N
Codeine	Y	N

Other: ______________________________

____

11. Do you have or have you had any of the following:

			Date Mo/Yr
Abnormal Bleeding	Y	N	____/___
AIDS or HIV Infection	Y	N	____/___
Anemia	Y	N	____/___
Arthritis	Y	N	____/___
Artificial Joints	Y	N	____/___
Artificial Valves	Y	N	____/___
Asthma	Y	N	____/___
Blood Transfusion	Y	N	____/___
Cancer	Y	N	____/___
Cardiac Pacemaker	Y	N	____/___
Chemotherapy	Y	N	____/___
Colitis	Y	N	____/___
Congenital Defect	Y	N	____/___
Diabetes	Y	N	____/___
Difficulty Breathing	Y	N	____/___
Drug / Alcohol Abuse	Y	N	____/___
Emphysema	Y	N	____/___
Epilepsy / Seizures	Y	N	____/___
Fainting	Y	N	____/___
Fever Blisters	Y	N	____/___
Frequent Urination	Y	N	____/___
Glaucoma	Y	N	____/___
Hay Fever / Allergies	Y	N	____/___
Heart Murmur	Y	N	____/___
Heart Attack	Y	N	____/___
Hemophilia	Y	N	____/___
Hepatitis A B C	Y	N	____/___
High Blood Pressure	Y	N	____/___
Kidney Aliment	Y	N	____/___
Leukemia	Y	N	____/___
Low Blood Pressure	Y	N	____/___
Metal Allergy / Sensitivity	Y	N	____/___
Mitral Valve Prolapse	Y	N	____/___
Psychiatric Problems	Y	N	____/___
Radiation Treatment	Y	N	____/___
Recent Weight Loss	Y	N	____/___
Respiratory Aliment	Y	N	____/___
Rheumatic Fever	Y	N	____/___
Shingles	Y	N	____/___
Sinus Problems	Y	N	____/___
Stomach / Ulcers	Y	N	____/___
Stroke	Y	N	____/___
Swollen Ankles	Y	N	____/___
Thyroid Problems	Y	N	____/___
Tuberculosis	Y	N	____/___
Venereal Disease	Y	N	____/___

Other:

____

____

____

DENTAL HISTORY

1. Why did you come to the dentist today? __________

____

2. Are you currently in pain? Y N

3. Do your gums bleed while brushing or flossing? Y N

4. Have you ever had periodontal disease? Y N

5. Are your teeth sensitive to hot or cold liquids/foods? Y N

6. Are your teeth sensitive to sweet or sour liquids / foods? Y N

7. Do you feel pain in any of your teeth? Y N

8. Do you have any sores or lumps in or near your mouth? Y N

9. Have you had any head, neck or jaw injuries? Y N

10. Have you ever experienced problems in your jaw? Y N

11. Do you have frequent headaches? Y N

12. Do you clench or grind your teeth? Y N

13. Do you bite your lips or cheeks frequently? Y N

14. Have you ever had any difficult extractions in the past? Y N

15. Have you ever had any prolonged bleeding following extractions? Y N

16. Have you had any orthodontic work? Y N

17. Are you satisfied with the appearance of your teeth? Y N

If NO, what would you like to change: (please circle)

Length Shade Spaces Crowding

Other: _______________________________________

____

MEDICAL AND DENTAL AUTHORIZATION RELEASE

I certify that the information that 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. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

____

Signature of patient or Parent of minor Date

INFORMED CONSENT AND PERMISSION FOR ANESTHETIC

Before you give your permission for the administration of anesthetic, you should understand there are associated risks. The possible general risks of local anesthetic may include allergic reactions, nausea, high or low blood pressure, and in extreme cases, cardiac arrest. There may be remote possibility of nerve involvement resulting in temporary numbness or tingling of the lip, chin, or tongue, and/or brushing at the site of administration.

____

Signature of patient or Parent of minor Date

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HIPAA Patient Consent

I understand that I have 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 provider involved in my treatment);
- Obtaining payment from third party payers (i.e. my insurance company);
- The day-to-day healthcare operations of your practice:
    - Send a recall appointment reminder to your home.
    - Leave appointment, billing or dental information on my answering machine/ voicemail/email
    - As giving permission to share appointment, billing or dental information with people at my contact address or contact telephone number.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a complete description of the uses and disclosures of my protected health information, and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are then bound to comply with this restrictions.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred before the date I revoke this consent is not affected.

Signed this ___________ day of ________________________________, 20_______.

Print Patient Name: ____

Relationship to Patient: ____

Signature: ____

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Dear Patient:

So we may acquire a comfortable working relationship with you, we would like to share the principals of our practice:

1. Your first visit will include diagnostic x-rays and an oral exam by the dentist. At this time you will be presented with a treatment plan specifically designed to meet your dental needs. If you have had x-rays taken at another dental office you may want to check your exam/x-ray frequency limits with your insurance carrier. Any treatment recommended by the dentist will be scheduled at this time.

2. Payment is due when services are rendered. You may use Visa, Mastercard, Discover and Debit card. We do not offer American Express or personal checks. We do offer Care Credit which is a company that finances outside of our office and offers interest free financing.

3. Insurance for most PPO and traditional plans are submitted by our office. We accept some HMOs. When you are given a treatment plan PLEASE BE AWARE THAT THIS IS ONLY AN ESTIMATE. There may be a minor balance due once the final payment is made by your insurance company. We ask that you be familiar with your insurance plan and benefits, with its exclusions and frequencies, as you expect us to be. If your insurance coverage changes, it is your responsibility to notify our office before your next visit, as this will take time to verify and enter the new information in our system. Please remember, filling insurance for our patients is a courtesy.

4. By law, children under the age of eighteen (18) years old may not attend the first initial dental appointment without being accompanied by a parent or guardian. All paperwork must be signed by their legal guardian. We ask younger children always be accompanied by their parent to all visits. PLEASE DO NOT DROP OFF YOUR CHILD TO ATTEND DENTAL VISITS ALONE. Parents need to be available to discuss dental treatment for each appointment. As a rule, we ask parents to remain in the outer reception area. We would like to build trust with each child as well as their parents.

5. Appointments are confirmed at least one day in advance. We ask for a confirmation return call from each patient. If you don't call within twenty-four (24) hours in advance to change or cancel your appointment, we reserve the right to charge a minimum of $40.00. Please be considerate of others and contact our office one day prior if you are unable to attend your appointment. Another patient may then be called to accept the appointment time which is left open. A patient can be dismissed from our practice after three (3) missed appointments without calling in advance. We are unable to secure a doctor/patient relationship when our patients do not attend their appointments. PLEASE REMEMBER, A CONFIRMATION CALL FROM OUR OFFICE IS A COURTESY.

6. Medical consult releases are required from your medical physician if a patient has a health issue which would require an antibiotic (PRE-MED) before dental appointments. At the time of your first dental appointment, we will be happy to fax this release to your physician for a written confirmation of the necessity for pre-med. We ask that we have this in our office by your next dental visit.

7. It is our commitment to practice high quality dentistry. This means to you the patient, we do not practice dentistry to meet the needs of your insurance coverage. We practice dentistry to fulfill the need of the patient. Please be reminded we will not neglect your dental health to restore only what your insurance company will pay for.

8. Finally, we would like to thank you for choosing AV Dental Care. We hope your experience with us is a pleasant one.

____

Patient/Legal Guardian Signature Date