

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU - THANK YOU

PATIENT LAST NAME: _____ FIRST: _____ INITIAL: _____

How do you wish to be addressed? _____ **DOB** _____

(☐ Single ☐ Married ☐ Divorced) (☐ Male ☐ Female) Full time Student? ☐ Yes ☐ No School _____

Address _____

City _____ **State** _____ **Zip** _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

Is patient covered by another dental insurance? ☐ Yes ☐ No Insurance Co. _____

How did you hear about our practice? Whom may we thank for your referral? _____

How important is your oral health to you? _____ How much do you like your smile? _____

In a scale 1-10, (1-4 Not Important - 5-7 Somehow Important - 8-10 Very Important)

What would you change about you smile? _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Last Name _____ First _____ Initial _____

Address _____ **DOB** _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer. I attest to the accuracy of the information on this page.

Signature _____ **Date** _____

PATIENT REGISTRATION

PLEASE COMPLETE ALL INFORMATION – THANK YOU!

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason for today's visit: _____ Date of last dental visit: _____
Former dentist: _____ Date of last dental x-rays: _____

Please check if you have/had:

Bad breath	☐	Gums swollen, tender, or bleeding	☐	Have you ever had an allergic reactions	☐
Blisters on lips or mouth	☐	Head, neck, or jaw pain or aches	☐	to Novocaine, local or general anesthetics?	
Burning sensation on tongue	☐	Lip or cheek biting	☐	<i>If Yes, please explain:</i>	_____
Chew on one side of mouth	☐	Loose teeth or broken fillings	☐		
Cigarette, pipe, or cigar smoking	☐	Mouth breathing	☐		
Smokeless tobacco	☐	Orthodontic treatment	☐	Have you had trouble from previous	☐
Dry mouth	☐	Nitrous Oxide	☐	dental care?	
Food collection between teeth	☐	Periodontal treatment	☐	<i>If Yes, please explain what happened:</i>	_____
Clench teeth	☐	Sensitivity to pressure or irritants	☐		_____
Grind teeth	☐	(cold, heat, sweets)			_____
Growths or sore spots in mouth	☐	How often do you floss?	_____		
		How often do you brush?	_____		

MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____
Physician's address: _____

Have you ever had a blood transfusion? Yes ☐ If Yes, please describe: _____

Have you had any serious illnesses or operations? Yes ☐ If Yes, please give approximate dates: _____

Pregnant? Yes ☐ Due Date? _____ Nursing? Yes ☐ Birth Control Pills? Yes ☐

Please check if you have/had:

Allergies, hay fever, sinusitis	☐	Heart Problems	☐	Thyroid Problems	☐
Anemia	☐	Hepatitis?	☐	Tonsillitis	☐
Arthritis, Rheumatism	☐	Type: _____		Tuberculosis	☐
Artificial Heart Valves	☐	Herpes	☐	Tumor or Growth on Head/Neck	☐
Artificial Joints	☐	High Blood Pressure	☐	Ulcer	☐
Asthma	☐	Any Immune Deficiency (incl. HIV/AIDS)	☐	Venereal Disease	☐
Asthma: Required Hospitalization	☐	Jaundice	☐	Weight Loss, Unexplained	☐
Asthma: Used Steroids	☐	Kidney Disease	☐	Do you wear contact lenses?	☐
Bleeding abnormally with operation/surgery	☐	Low Blood Pressure	☐	Do you consume alcoholic beverages?	☐
Blood Disease, Clotting Disorders	☐	Mitral Valve Prolapsed	☐	Are you currently under the care of a	☐
Cancer	☐	Osteopenia	☐	Physician?	
Chemical Dependency	☐	Osteoporosis	☐	Are you allergic/sensitive to Latex?	☐
Chemotherapy	☐	Pacemaker	☐	Allergic to penicillin, Aspirin or Other Drugs?	☐
Circulatory Problems	☐	Radiation Treatments	☐	<i>If Yes, please specify:</i>	_____
Cortisone Treatments	☐	Respiratory Disease	☐		
Cough, persistent or bloody	☐	Rheumatic Fever	☐	Are you currently taking any Medications?	☐
Diabetes	☐	Scarlet Fever	☐	<i>If Yes, please list:</i>	_____
Emphysema	☐	Shortness of Breath	☐		
Epilepsy	☐	Sinus Trouble	☐		
Fainting	☐	Sickle Cell Anemia	☐		
Glaucoma	☐	Skin Rash	☐		
Headaches	☐	Stroke	☐		
Heart Murmur	☐	Swelling of Feet/Ankles	☐		

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ **Date:** _____

Reviewed by: _____ Date: _____

DENTAL & MEDICAL HEALTH HISTORY

PATIENT NAME: _____

DATE: _____

PAYA Dental, is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.**
- **PAYA DENTAL PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments for visits by unaccompanied minors.

INSURANCE

PAYA Dental provides insurance company billing as a *courtesy* to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by **PAYA** Dental staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to **PAYA** Dental. However, if you are paid by the insurance company instead of **PAYA** Dental, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

MEDICARE/ MEDICAID/ WORKER'S COMPENSATION

If you are covered by Medicare, Medicaid, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the **PAYA** Dental office on the date of service.

DELINQUENT PAYMENTS

Office policy after 30 days of outstanding balance the account will be handling by the collection department.

BROKEN APPOINTMENTS

Unless cancelled at least 24 hours in advance, our office policy is to charge for BROKEN appointments \$35.00. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____

Date _____

FINANCIAL POLICY



Dental Warranty

Our practice is proud of the dental care we provide for you and your family. Our goal is not simply to treat and avoid any dental or medical problems, but to prevent dental complications that can cause you to lose your time and money. The long-term success of the treatments you receive depends on the continuity you give them at home. We offer dental exams and cleaning every 3, 4 or 6 months depending on your oral health. With this in mind, we offer the following limited dental warranties:

Dental Sealants:

Dental sealants are a layer that the dentist places on the grooves of the back teeth to protect them from cavities.

Fillings (tooth color)

If a filling is the recommended treatment, we will replace or repair it in case of a failure for a period of 3 months. If the tooth breaks and requires a crown, it will be credited to the cost of filling or towards the crown. The only exception to this is if the patient has evidence of bruxism or tightness and does not use a bite protect or sleeping device, then the warranty will be voided.

Root Canal Treatment

The root canal is 95% successful and usually requires a crown afterwards, but 5% of root canal fails occasionally. If the root canal fails within a year, we will give you a half of the amount paid towards the root canal as towards the root canal and apply it to any implant, bridge or removable partial.

Crowns, Bridges, Porcelain Veneers and Inlays/Onlays

These procedures are delicate so the patient must take into account the importance of home care to make it last. Paya Dental guarantees these procedures for one year. We will replace or repair them at no charge within 12 months if they break or deteriorate with normal use. The only exemption to this is if the patient has evidence of bruxism or biting too hard and does not wear a bite protector or sleeping device, then the warranty will be voided.

Full Dentures and Partial Dentures

Dentures and partial dentures have a warranty for a period of 6 months if any tooth breaks or the acrylic breaks. This warranty is only valid for manufacturing defect and not for misuse or accidents.

Bite Guards for Grinding and Clenching

We guarantee these devices for 6 months against regular wear breakage. This warranty does not include dropping them, washing them with inappropriate products or any accidents. Patients should ALWAYS bring their oral appliance to their appointments to confirm that the appliance is fitting and working properly.

Invisalign, Braces and Orthodontic Care

Retention! Retention! Retention! We recommend that you wear retainers every night, as long as you want to have a beautiful, aligned smile.

Dental Implants

Implants in our office have a success rate of 98%. Implants have no real allergies, but 2% of the time they can be rejected by certain patients and need to be removed. If a new implant fails within the first year, then you will be given a credit for the implant and associated services: bone grafts, abutments and crowns when repeated. If the success is reached within 1 year, the patient will have full responsibility for the payment, if not then we will be half of the amount paid towards treatment as a credit to be used in other options, such as conventional bridges, removable partial or full dentures. Implants are a wonderful service to help our patients smile and feel safe.

Note: As you can see, we are confident in the durability of our treatment as diagnosed for you. The main key to your long-term success is to devote a few minutes a day to your oral health. This includes brushing, flossing, fluoride treatment and any prescribed products. We recommend cleaning your retainer, denture, partial, bite protector, night protector with sonic cleaner which will help them last many more years. The second key to success is regular professional examinations and cleanings, x-rays, and fluoride treatments (intervals of 3,4,6 months, depending on your oral condition.) Help us, help you preserve your teeth for life. If you return for regular checkups and cleanings, your dental work and smile will last much longer!

This warranty is null and void if the patient does not maintain his/her regular cleaning and check-up appointments every 3,4, or 6 months as recommended by the Dentist or the Hygienist.

Patient Signature: _____

Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with **PAYA DENTAL**, "Notice of Privacy Practices", and I am giving my consent for the use and disclosure of Protected Health Information as required and / or permitted by law.

Confirmo que se me ha proveído con la "Nota De Practicas De Privacidad" de **PAYA DENTAL, y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.*

Patient Name: (please print) _____

Nombre Del Paciente: (nombre en letra de molde por favor)

Patient Signature: (or legal representative; proof may be requested) _____

Firma Del Paciente: (o representante legal; prueba puede ser requerida)

Date: (dd/mm/yy) _____

Fecha: (dd/mm/aa)

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

*CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **PAYA DENTAL, (PD)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **PD** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **PD** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **PD** and me and consent to the conditions outlined here in. Any questions I may have have been answered.

***Propósito:** Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. **PAYA DENTAL, (PD)** ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Transmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **PD** usará formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, **PD** no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre **PD** y yo consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me ha sido respondida.

Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente

My Consented Email Address is: _____

*Mi Correo Electrónico Consentido es:

My Consented for Text Messaging to: _____

*Mi Mensaje de Textos Consentido a:

X
Patient Signature * Firma del Paciente

Date *Fecha

In Case of Any Emergency Please Call 911 or Proceed to the Nearest Emergency Room, DO NOT USE THIS WAY OF COMMUNICATION FOR THAT PURPOSE.
En Caso de Cualquier Emergencia Por Favor Llame al 911 o Proceda al Centro de Emergencia Cercano, NO USE ESTA FORMA DE COMUNICACIÓN PARA ESE PROPOSITO



I _____ give my consent for information and/or images/photographs about MYSELF/MY CHILD OR WARD/MY RELATIVE [circle correct description] relating to the subject matter above to appear in the identified website (payadentalweb.com) and associated publications.

I understand the following:

- The information will be published without my name. I understand that complete anonymity cannot be guaranteed and someone may be able to recognize me.
- The text of the article will be edited for style, grammar, consistency, and length.
- The information may be published on our website, and or social media which are distributed worldwide. Readers include doctors, but also other members of the public.
- I can revoke my consent at any time before publication, but after the information has been published, it will not be possible to revoke consent.
- I will not receive any compensation, financial, or otherwise for the use of the information.

Signed: _____

Date: _____

Yo _____ doy mi consentimiento para obtener información y / o imágenes / fotografías de MI MISMO / MI NINO / MI FAMILIAR [círculo en la descripción correcta] relacionadas con el tema mencionado anteriormente para que aparezcan en el sitio web identificado (payadentalweb.com) y publicaciones asociadas.

Entiendo lo siguiente:

- La información será publicada sin mi nombre. Entiendo que no se puede garantizar el anonimato completo y que alguien puede reconocerme.
- El texto del artículo se editará por estilo, gramática, consistencia y longitud.
- La información puede publicarse en nuestro sitio web y en las redes sociales que se distribuyen en todo el mundo. Los lectores incluyen médicos, pero también otros miembros del público.
- Puedo revocar mi consentimiento en cualquier momento antes de la publicación, pero después de que se haya publicado la información, no será posible revocar el consentimiento.
- No recibiré ninguna compensación, financiera o de otro tipo por el uso de la información.

Firma: _____

Date: _____

PAYA DENTAL

Authorization to Share my Dental Care Information

We are committed to providing the best quality clinical care and clear communication to our patients and their authorized guardian. In our practice, we often have our patient accompany by a friend or a family member to their appointment. Individuals other than authorized guardians are NOT allowed to accompany patient inside the treatment room, nor have access to patient dental care information or approve consent to treatment. This ensures your rights and responsibilities as the responsible party are not inadvertently over stepped.

If you are would like a family member or a close friend, to have access to your dental care information and dental treatment including financial decisions, the following form MUST be completed prior to us releasing information.

We take our responsibility to your oral health with the utmost respect and are continually striving to improve our services and communication to all your families, thank you, again, for entrusting your oral health to our care.

Date:

I, patient at PAYA DENTAL give full authorization to disclose my personal information, including dental appointment information, dental treatment plans, discuss dental financials and make changes to my dental care. I can be contact at the following telephone number:

Autorizacion para compartir mi informacion Dental

Estamos comprometidos a proporcionar la mayor atencion clinica y una comunicacion clara a nuestros pacientes y su tutor autorizado. En nuestra practica, amenudo nuestros pacientes son acompañados por un amigo o un familiar a su cita. Las personas que no sean tutores autorizados NO pueden acompañar al paciente dentro de la sala de tratamiento, ni tienen acceso a la informacion dental del paciente, y no pueden aprobar el consentimiento para el tratamiento dental. Esto garantiza sus derechos y responsabilidades, ya que la parte responsable no se pasa inadvertidamente.

Si desea que un familiar o un amigo cercano tenga acceso a su informacion personal y dental incluyendo decisiones financieras, Debe completar el siguiente formulario antes que divulguemos informacion.

Asumimos nuestra responsabilidad con respeto a su salud bucal con el mayor respeto y nos esforzamos continuamente por mejorar nuestros servicios y comunicacion con toda su familia, gracias nuevamente, por confiar su cuidado bucal con nosotros.

Fecha:

Yo, paciente de PAYA DENTAL, doy autorización total para divulgar mi información personal, incluida la información de citas dentales, planes de tratamiento dental, discutir finanzas y realizar cambios en mi cuidado dental. Puedo contactarme en el siguiente número de teléfono:

1. , relationship/relacion:
2. , relationship/relacion:
3. , relationship/relacion: