PATIENT REGISTRATION

Date: _____

Sonrisa Dental, P.A.

Patient Name _____ Birthdate _____ Age_____
First Middle Last

SSN#_____DL#_____ Occupation _____

Home Address_____ Zip _____

Home # _____Cell # _____ Work #_____

E- Mail Address _____

Employer Name and Address _____

Marital Status: Single___ Married___ Divorced___ Widowed___ Spouses Name: _____ Cell # _____

Person Responsible for Account_____Relationship _____

SSN # _____DL#_____DOB_____

Home Address (if different)_____Zip_____

Employer & Address_____

Occupation_____Work # _____

Do you have Dental Insurance? Yes No Insurance Company Name_____

Referred By_____Physician_____

Emergency Contact_____Relationship_____

Address_____Zip_____Phone_____

Are you currently having dental problems? Yes No

What are your concerns? *Circle as many as applicable:* (Fear/Anxiety) (Appearance) (Losing Teeth) (Gum/Periodontal Disease) (Cavities) (Oral Cancer) (Wasting/Exceeding Dental Insurance Limits) (Your General Health) (Routine Checkup) (Cleaning) (Other) _____

Circle yes or no to the following questions:

1. Are you presently under the care of a physician? ..... Yes No
2. Have you ever had high blood pressure? ..... Yes No
3. Has a physician ever said you had heart trouble? ..... Yes No
4. Do you have Mitral Valve Prolapse? ..... Yes No
5. Have you ever had abnormal bleeding following a cut or extraction? ..... Yes No
6. Have you ever had an anesthetic (either local or general)? ..... Yes No
7. Has a physician or dentist ever said you had a tumor or cancer? ..... Yes No
8. Are you allergic to Penicillin, Codeine, local Anesthetic other medicine? ..... Yes No
   If so, what? _____
9. Is the patient allergic to anything other than medicine? (e.g. latex or metals)? ..... Yes No
   If so, what? _____

Do you have or ever had:

1. Rheumatic fever? ..... Yes No
2. Cancer/Chemo? ..... Yes No
3. Anemia, leukemia or low platelets ..... Yes No
4. Epilepsy or convulsions? ..... Yes No
5. Asthma or hay fever? ..... Yes No
6. Tuberculosis ..... Yes No
7. Diabetes? How long ..... Yes No
8. Kidney trouble? ..... Yes No
9. Liver trouble or jaundice? ..... Yes No
10. Thyroid trouble or goiter? ..... Yes No
11. Syphilis? ..... Yes No
12. Fainting or dizziness? ..... Yes No
13. Glaucoma? ..... Yes No
14. Arthritis? ..... Yes No
15. HIV AIDS? ..... Yes No
16. Stroke? ..... Yes No
17. Stomach ulcer? ..... Yes No
18. Heart murmur? ..... Yes No
19. Prostate trouble? ..... Yes No
20. Hepatitis? ..... Yes No
21. Eczema or hives? ..... Yes No
22. Psychiatric treatment? ..... Yes No
23. Are you pregnant? ..... Yes No

Are you now taking:

1. Drugs for high blood pressure? ..... Yes No
2. Drugs for sleep? ..... Yes No
3. Cortisone, steroids or ACTH? ..... Yes No
4. Anticoagulants or blood thinner?. ..... Yes No
5. Tranquilizers or sedatives? ..... Yes No
6. Antibiotics? ..... Yes No
7. Insulin? ..... Yes No
8. Have you ever taken Fen-Phen? ..... Yes No
9. Others? ..... Yes No
10. List of medications:_____

_____

11. Have you been under the care of a physician for any major illness or injury other than those noted above. If so, list.

_____

I Understand That Payment Is Due At Time Of Service.

I will pay today by: CASH ☐ CHECK ☐ CREDIT CARD ☐

I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

Signature:_____**Date:**_____

SONRISA DENTAL, P.A.
Justin Barber, D.D.S.
Zade Faraj, D.D.S.

Insurance Policy

We are happy to file the necessary form to see that you receive the full benefits of your coverage. However, insurance companies only pay the assigned percentages on what they feel like service should cost not what we charge. Due to this, you may be charged the difference between our fee and what your insurance will pay. Claims are paid according to usual, customary, and reasonable fee which varies per insurance company.

Your dental insurance is a contract between you, your employer and the insurance company. SONRISA DENTAL is in no way involved in this contract.

Our Policy Regarding Dental Insurance

Though your dental insurance is your responsibility, we can help. We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies which reduces your immediate out-of-pocket expense.

Regardless of what we may calculate for your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. ***You must understand, we cannot forecast what your insurance will pay.***

It often takes us a considerable amount of time to try to collect your insurance payment for you. We often need your help to discuss your situation directly with your insurance. Our staff strives to give you the best service possible. It is important that our patients understand our office policies and work with us to exceed our expectations.

I authorize release of any information relating to my claim.

Signature: _____ **Date**: _____

I authorize payment directly to Sonrisa Dental, P.A.

Signature: _____ **Date:** _____

I understand that all fees not paid by my insurance are my responsibility.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____
(For Office Use ONLY)

Note: if you have an insurance card, please give it to the front desk person so they can make a photocopy which will help in speeding of the processing of your insurance claim.

CANCELATION POLICY

A broken appointment is a loss to everyone. We value our time and our patient's time greatly. We make every effort to make your appointment as comfortable and convenient as possible. We do not double book our schedule. Your appointment time is reserved just for you. In order to achieve this, you must notify us to reschedule an appointment no less than 48 hours in advance. Any cancelation or reschedule less than 48 hours in advance will be considered a late cancel. A missed appointment without notification or contact will be considered a broken appointment. If a patient has more than two late cancelations in a 12 month period, or more than one broken appointment in a twelve month period, then he or she will no longer be a patient of Sonrisa Dental, P.A. and will be referred to another dental practice. This is necessary to maintain a predictable schedule and keep your waiting time to an absolute minimum. We hope you value your time as much as we do and abide by these rules.

I understand and accept the aforementioned terms and conditions.

_____ _____

Patient or Guardian Date

POLIZA DE "CANCELACION DE SERVICIO AL PACIENTE"

ESTIMADO PACIENTE:

En Sonrisa Dental valoramos nuestro tiempo y el tiempo de nuestros pacientes. Para poder cumplir mejor con este servicio necesitasmos de su colaboracion.

- Si no puede cumplir con su cita y necesita cancelarla, favor de avisar con 48 horas de anticipacion.
- Si tiene mas de dos cancelaciones en el lapso de 12 meses sin avisarnos con 48 horas de anticipacion, Sonrisa Dental tiene el derecho de cancelar sus servicios y el paciente sera referido a otra oficina dental.

Esta clausula es necesaria para mantener el orden de nuestro tiempo y prestarle un mejor servicio a nuestros pacientes.

Yo entiendo estas poliza y sus condiciones y acepto los terminos y condiciones.

_____ _____

Firma Fecha

Sonrisa Dental, P.A.

DENTAL TREATMENT CONSENT FORM

1. ___**DRUGS AND MEDICATIONS:**
   I understand that antibiotics, analgesics, and other medications can cause redness, swelling of tissues, pain, itching, vomiting and /or anaphylactic shock. It is the responsibility of the patient to inform us of any allergies he/she may have.
2. ___**CHANGES IN TREATMENT PLAN:**
   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination.
3. ___**REMOVAL OF TEETH:**
   I understand that removing teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. I understand that some of the risks involved in having teeth removed are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips tongue and surrounding tissue that can last for an indefinite period if time or a fractured jaw. I understand that I may need further treatment by a specialist o even hospitalization if complications arise during or following treatment, the cost of which Is my responsibility.
4. ___**CROWN, BRIDGES, AND VENEERS:**
   I understand that sometimes it is not possible to match the color of natural teeth with artificial teeth. I also understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer, (including shaping, fit, size or color) will be before cementation.
5. ___**DENTURE: COMPLETE OR PARTIAL:**
   I realize that full or partial dentures are artificial, constructed of plastic metal, and /or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures will be the: teeth in was" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. This cost is not included in the initial denture fee.
6. ___**ENDODONTIC TREATMENT: (ROOT CANAL):**
   I realize there is no guarantee that root canal treatment can save my tooth and that complication can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extracted through the root, which does not necessarily affect the causes of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment.
7. ___**PERIODONTAL LOSS:**
   I understand that I may have a serious condition causing gum and bone infection or loss and that it can lead to the loss of teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and /or extractions. I understand that undertaking any dental procedure may have further adverse effects on my periodontal condition.
8. ___**FILLINGS:**
   I understand that a more extensive restoration than originally planned, or possible root canal therapy, may be required due to additional conditions discovered during tooth preparation. I understand that significant changes in response to temperature may occur after tooth restoration such as temporary sensitivity or pain. I also understand that if my tooth does not respond to treatment with a filling, further treatment such as root canal therapy or crown may be necessary. I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns. I understand I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.
9. ___**CONSENT TO EXAMINATION**: I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. Including but not limited to: Examinations, X-rays, Photographs, Impressions and Anesthetic.

Print Name: _____ **Date**: _____
(*Patient*)

Signature: _____
(*Responsible Party if Minor*)

Witness: _____(*For Office Use*)