Fernandez Dental Office Flagler
8080 West Flagler Street Suite 2C
Miami, FL 33144
Phone: (305)260-9990 Fax: (305)260-9991

PATIENT INFORMATION (CONFIDENTIAL)

Today's Date: ___/___/_____

Patient's Name_____ ☐ Male ☐ Female

Date Of Birth____/_____/____ Social Security Number: _____ (Mandatory if you have insurance)

Address: _____Apt# _____City:_____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work Phone: (_____) _____ Ext.:_____

Cell Phone: (____) _____

Email Address: _____

In case of emergency who can we contact? Name : _____ Phone : _____

Relationship to patient : _____

Marital Status: ☐Minor ☐Single ☐ Married ☐Divorced ☐ Separated

Name of Spouse:_____ _____

If you are a student, please provide your school's Name: _____City _____ State _____ Zip _____
☐Full Time Student ☐ Half Time Student

WHO CAN WE THANK FOR REFFERING YOU TO THE OFFICE ?

☐The Flyer ☐TV-Univision ☐23 TV-Telemundo ☐51 ☐Radio-Mambi ☐710 AM ☐Radio-Zeta 92.3 ☐Bill Board
☐Building Sign ☐Referred By: _____

IF YOU ARE A MINOR, WHO IS THE RESPONSIBLE PARTY?

Name : _____ Relationship with patient : _____
Address: _____ Apt# _____City:_____ State: _____Zip Code: _____
Employer : _____ Work Phone Number : _____
Is this person a patient of the office? ☐Yes ☐No

DENTAL INSURANCE INFORMATION

Employer : _____ Date of Employment : _____ / _____/_____
Name of Insurance Carrier : _____ Insurance Phone number :_____
Name of Primary/Subscriber: _____ Date of Birth : _____/_____/_____
Member ID :_____ Primary's Social Security Number : _____
Group Number : _____ Relationship to patient : _____

MEDICAL INSURANCE INFORMATION

Name of Insurance Carrier : _____ Insurance Phone number :_____
Name of Primary/Subscriber: _____ Date of Birth : _____/_____/_____
Member ID :_____ Primary's Social Security Number : _____
Group Number : _____ Relationship to patient : _____

PATIENT DENTAL HISTORY

☐Do your gums bleed while brushing flossing?
☐Are your teeth sensitive to hot or cold liquids/ foods?
☐Do you feel pain to any of your teeth?
☐Do you have any sores or lumps in or near your mouth?
☐Have you had and head, neck or jaw injuries?
☐Have you ever experienced any of the following
Problems in your jaw?
Clicking,
Pain (joint, ear, side of face),
Difficulty in opening closing.
Difficulty in chewing
☐ Do you Clench or grind your teeth?

☐Do you have frequent headaches?
☐Have you ever had any difficult extractions in the past?
☐Do you bite your lips or cheeks frequently?
☐Have you ever had any prolonged bleeding following extractions?
☐Have you had any orthodontic treatment?
☐Do you wear dentures or partials? If yes. Date of placement:
____/____/____
☐Have you ever received oral hygiene instructions regarding the care Of your teeth and gums?
☐ Do you like your smile

Name of Previous Dentist: _____ Phone Number : _____
Date of Last Exam: _____ Date of Last X-rays : _____

PATIENT'S MEDICAL HISTORY

Are you taking any of the following Medications?

☐Pain Medications including aspirin
☐Medication for Nervous system
☐Insulin
☐Stimulants
☐ List of other medications taken: _____

☐Medication for osteoporosis
☐Tranquilizers/Muscle Relaxants
☐Blood Thinners

Please Provide for us the information of a pharmacy should the Doctor need to Prescribe medications:

Name of the pharmacy: _____
Address : _____
Phone Number: _____

Do you have or have had any of the following medical conditions?

☐High Blood Pressure
☐Heart Disease
☐Heart Attack
☐Cardiac Pacemaker
☐Heart Murmur
☐Heart Trouble
☐Mitral Valve Prolapsed
☐Angina
☐Stroke
☐Rheumatic Fever
☐Swollen Ankles
☐Fainting/ Seizures/Epilepsy
☐Asthma
☐Low Blood Pressure
☐Leukemia
☐Diabetes

☐Hay Fevers
☐Thyroid Problems
☐Tuberculosis
☐Radiation Therapy
☐Glaucoma
☐Frequently tired
☐Respiratory Problems
☐Recent Weight loss
☐Liver Disease
☐Production of Sputum (including blood streaked)
☐Shortness of Breath
☐Fever
☐Night Sweats
☐Psychological Problems
☐Blood Disorders
☐Nervousness

☐Kidney Disease
☐Herpes
☐AIDS or HIV infection
☐Easily Winded
☐Stomach Troubles/ Ulcers
☐Anemia
☐Emphysema
☐Cancer/Chemotherapy
☐TMJ
☐Arthritis
☐Sinus Problems
☐Cosmetic Surgery
☐Head/Neck/Back Pain
☐Sexual Transmitted Disease
☐Joint Replacement or Implant
☐Hepatitis / Jaundice

Please list any other medical conditions or symptoms you have :

_____

Are you allergic to any of the following?

☐Local Anesthetics ☐ Penicillin or any other antibiotics ☐Sulfa Drugs ☐Barbiturates ☐Sedatives

☐Iodine ☐Aspirin ☐Any Metals ☐Latex Rubber ☐ Other _____

Do you use tobacco? ☐YES ☐ NO Do you use contact lenses? ☐YES ☐ NO
Do you use controlled substances? ☐YES ☐ NO Do you require pre-medication? ☐YES ☐ NO

For Women :
Are you Pregnant or think you may be pregnant? ☐YES ☐ NO Are you Nursing? ☐YES ☐ NO
Are you taking an oral contraceptive ☐YES ☐ NO

In the event that you are pregnant, a letter from your OBGYN is required authorizing Fernandez Dental to attend you.

If you have any questions, we encourage our patients to clear any doubts about our services. Our service is at its best when There is a mutual understanding between Fernandez Dental and Their patients.

FINANCIAL AGREEMENT

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.
Fernandez Dental Office requires that all services provided be paid in full on the date the service was provided, unless other Financial arrangements have been established with the Office Administrator. In the event of your failure to pay in accordance With these terms, you will be responsible for Fernandez Dental's legal fees and costs, collection agency expenses, interest Charges, and any other expenses incurred in the attempt to collect the unpaid debt. The terms of this agreement apply to All services provided by Fernandez Dental.

AUTHORIZATION

I certify that I have read, understand, and agree to the above information and agreement. I further certify that the above Questions have been accurately answered. I understand that providing inaccurate information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis 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 hereby Consent to have photographs, x-rays and any other means of recording taken in order to improve my dental treatment that My dentist deems necessary.

X_____
Signature of Patient or Legal Guardian

LAZARO FERNANDEZ, D.D.S.

8080 West Flagler St., Suite2C, MIAMI, FL 33144

HIPAA

PATIENT ACKNOLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND RECEIVE A COPY OF LAZARO FERNANDEZ, D.D.S. NOTICE OF PRIVACY PRACTICES.

With my consent **LAZARO FERNANDEZ, D.D.S.** may use and disclose protected health information about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **LAZARO FERNANDEZ, D.D.S.** Notice of Privacy Practices for a more complete description of such uses and disclosures. **LAZARO FERNANDEZ, D.D.S.** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at **LAZARO FERNANDEZ, D.D.S., 8080 West Flagler St., Suite2C, MIAMI, FL 33144.**

With my consent, **LAZARO FERNANDEZ, D.D.S.** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. **I understand that I have the right to request a restriction on how my information is divulged or mailed, should I wish to exercise this right I understand I need to request it in writing.**

With my consent, **LAZARO FERNANDEZ, D.D.S.** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. **I also understand that I have a right to restrict and limit where my information is sent, should I wish to exercise my right I understand I need to request it in writing.**

With my consent, **LAZARO FERNANDEZ, D.D.S.** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **LAZARO FERNANDEZ, D.D.S.** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
By signing this form, I am consenting to **LAZARO FERNANDEZ, D.D.S.** use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **LAZARO FERNANDEZ, D.D.S.** may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____

Patient's Name Date

Good faith attempt to obtain the signature from the patient. Describe the reason why patient did not sign the form:

_____

_____

_____ _____

SIGNATURE OF THE STAFF MEMBER DATE