Gallegos Family Dentistry

Registration Form & Health History

Patient Name: _____ Date of Birth: _____ Sex: Male/Female

Home Address: _____ City/State: _____ Zip Code: _____

Billing Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Email: _____

Emergency Contact: _____ Phone Number: _____

Employer/Occupation: _____ SSN: _____

Primary Dental Insurance: _____ ID #: _____

Subscriber Name: _____ Subscriber SSN/DOB: _____

Name of your medical Doctor: _____ Date of Last Visit: _____

Name of Previous Dentist: _____ Date of Last Visit: _____

Who may we thank for referring you to our office: _____

Medical & Dental History

I. Circle Appropriate Answer (Leave blank if you do not understand the question).

1. Is your general health good? Yes No
2. Has there been a change in your health within the last year? Yes No
3. Have you been hospitalized or had a serious illness in the past 3 years Yes No
   a. If Yes, Why? _____
4. Are you being treated by a physician now? Yes No
   a. For What? _____
5. Have you had problems with prior dental treatment? Yes No
6. Are you in pain now? Yes No

II. Have you ever experienced?

7.	Chest Pain(angina)	Yes	No	18. Dizziness	Yes	No
8.	Swollen Ankles	Yes	No	19. Ringing in ears	Yes	No
9.	Shortness of breath	Yes	No	20. Headaches	Yes	No
10.	Recent weight loss, fever, night sweats	Yes	No	21. Fainting Spells	Yes	No
11.	Persistent cough, coughing up blood	Yes	No	22. Blurred Vision	Yes	No
12.	Bleeding problems, bruising easily	Yes	No	23. Seizures	Yes	No
13.	Sinus Problems	Yes	No	24. Excessive Thirst	Yes	No
14.	Difficulty swallowing	Yes	No	25. Frequent Urination	Yes	No
15.	Diarrhea, Constipation, blood in stools	Yes	No	26. Dry Mouth	Yes	No
16.	Frequent vomiting, nausea	Yes	No	27. Jaundice	Yes	No
17.	Difficulty urinating, blood in urine	Yes	No	28. Joint pain/stiffness	Yes	No

III. Do you have or have you ever had any of the following conditions:

1.	Heart Disease	Yes	No	12. HIV/AIDS	Yes	No
2.	Heart Attack, heart defects	Yes	No	13. Tumors/Cancer	Yes	No
3.	Heart Murmurs	Yes	No	14. Arthritis/Rheumatism	Yes	No
4.	Rheumatic Fever	Yes	No	15. Eye Disease	Yes	No
5.	Stroke, Hardening of Arteries	Yes	No	16. Skin Disease	Yes	No
6.	High Blood Pressure	Yes	No	17. Anemia	Yes	No
7.	Asthma, TB, Emphysema, Lung Disease	Yes	No	18. VD (syphilis, gonorrhea)	Yes	No

8.	Hepatitis, other liver disease	Yes	No	19.Herpes? _____	Yes	No
9.	Stomach problems, ulcers	Yes	No	20. Kidney, Bladder Disease	Yes	No
10.	Allergies: drugs, foods, medication, latex	Yes	No	21. Thyroid, Adrenal Disease	Yes	No
11.	Family History of Diabetes, Heart prob, Cancer	Yes	No	22. Diabetes	Yes	No
12.	Oral Abscess/ Cold Sores	Yes	No	23. Blood Thinners	Yes	No

IV. Do you have or have you ever had any of the following.

1.	Psychiatric Care	Yes	No	6. Hospitalization	Yes	No
2.	Radiation Treatments	Yes	No	7. Blood Transfusions	Yes	No
3.	Chemotherapy	Yes	No	8. Surgeries (3 yrs)	Yes	No
4.	Prosthetic Heart Valve	Yes	No	9. Pacemaker	Yes	No
5.	Artificial Joint	Yes	No	10. Contact Lenses	Yes	No

V. Are you taking any of the following:

1.	Recreational Drugs	Yes	No	3. Tobacco	Yes	No
2.	Drugs, Medications	Yes	No	4. Alcohol	Yes	No

a. Please List All Medications & Allergies:

_____

_____

_____

Do you have or have you had any other diseases or medical problems not listed on this form? If yes, please explain:

_____

_____

_____

WOMEN ONLY:

1.	Are you pregnant, trying to get pregnant, or nursing?	Yes	No
2.	Are you taking any type of birth control?	Yes	No

I have answered every question completely and accurately to the best of my knowledge. I will inform my dentist of any changes that might occur in my health or medications.

Patient Name (Print): _____ Patient Signature: _____

Date: _____

Gallegos Family Dentistry

General Dentistry Consent/Privacy Notices

I consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I may undergo procedures in all phases of dentistry, including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. I will pay in full any cost of treatment or insurance co-payments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for any cost that my insurance does not cover.
5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment if I am unsure about any of it.

I have reviewed and received a copy of the office's Notice of Privacy Practices. _____ Initial

Patient Name (Print): _____ Date: _____

Patient/Guardian Signature: _____

Gallegos Family Dentistry

Photography Release Form

I hereby authorize Gallegos Family Dentistry, to publish photographs taken of me during my dental office visits, and my name and likeness, for use in the Gallegos Family Dentistry's print, online and video-based marketing materials, as well as other office publications.

I hereby release and hold harmless Gallegos Family Dentistry from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other dental office publications. I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

I hereby release Gallegos Family Dentistry, its contractors, its employees and any third parties involved in creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

- ***I authorize*** Gallegos Family Dentistry to take and publish pictures of myself or of my completed dental work for marketing purposes.
- ***I DO NOT authorize*** Gallegos Family Dentistry to take and publish pictures of myself or of my completed dental work for marketing purposes.

I have reviewed this document and marked my choice above, if any changes are decided in the future, I will notify the office.

Patient Name (Print): _____ Date: _____

Patient Signature: _____

Gallegos Family Dentistry

Financial Policy

To Our Valued Patient,

In order to keep our fees from rising and keep up with the monumental expenses of bookkeeping and billing services, we have opted to offer our patients new payment policies. This will help reduce our overhead, thus passing the savings along to our patients by being able to maintain our current fee schedule.

1. In order to keep billing to a minimum, we ask that payment for services be ***made at the time of visit, unless previous financial arrangements have been made.*** The entire cost is incurred on the first visit for services requiring lab work, such as: crowns, bridges, dentures, partials, occlusal guards, etc., and must be paid in full before cementation. Payments may be made by cash, check, and credit card or through Care Credit and/or Lending Club Patient Solutions (credit approval is required).
2. Custom made items such as crowns, bridges, partials, etc., take more than one appointment. In the event a patient does not come in for the completion of their treatment ***payment in full is still due.***
3. Patients having dental insurance will be asked to pay their deductible and estimated portion of the fee, at the time the services are rendered and will also be responsible for any balance remaining after the insurance company has paid the claim.
4. While the filing of the insurance claim is a courtesy that we extend to our patients, we must emphasize that as dental providers, our relationship is with the patient, not the insurance company. If we do not receive payment from your insurance company within 90 days, payment becomes your responsibility.
5. Unpaid accounts will not be held over 90 days and will be turned over for collections without notice.
6. Time is set aside specifically for you when you make an appointment. Therefore, a minimum of 2 business days notification is required if you are unable to keep your appointment. Patients canceling without a 2 business day notice or who do not show up for their appointment will be charged a broken appointment fee of $50.00. _____ please initial. Cancellations left on our voicemail service after hours will not be accepted if within this 2 business day requirement.

I agree to pay all cost of collections for any outstanding amounts to my account including a reasonable attorney fee. I understand this may increase my outstanding charges. _____ Please initial.

I have read the above financial policies and agree to abide by them. _____ Please initial.

All treatment plans are ESTIMATES provided by your insurance and are subject to change. These treatment plans are valid for 6 months from the date presented.

Method of payment (Check all that apply): ○ Insurance ○ Cash ○VISA ○Mastercard ○Discover ○Care Credit ○Lending Group/Spring Stone ○Check

_____ _____ _____

Patient/Guardian Signature Patient Name (Print) Date