



Welcome To Our Office!

All information obtained from this document will remain strictly confidential.

Patient Name _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Phone Numbers: (____) _____ Work (____) _____ ext# _____ Cell:(____) _____

Date of Birth ____/____/____ Age ____ Sex ____ Marital Status _____

Full Time Student? Y/N School Attending _____

Employer _____ Employer Address _____

SS# _____ - _____ - _____ DL# & State _____ E-Mail Address _____

How did you hear about our office? _____

Other family members seen by us: _____

Person Responsible for Account

Name _____ Relation to Patient _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Phone Numbers:(____) _____ Work (____) _____ ext# _____ Cell:(____) _____

Employer _____ Employer Address _____

SS # _____ - _____ - _____ DL# & State _____ E-Mail Address _____

Payment Option for Today's Visit (circle one) Cash/Check/Debit card/MasterCard/Visa*

Dental Insurance

Insurance Company Name _____ Phone Number (____) _____

Group Plan # _____

Insured Name _____ Relation to Patient _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Employer _____ Date of Birth of Insured _____

SS# _____ - _____ - _____ DL# & State _____

Luis R. Perez, DDS, PA
1616 W. Hebron Parkway
Ste #100
Carrollton, TX 75010
T-214-731-0558
F-214-731-0538

Cancellation and Rescheduling Policy

It is very important to us that you receive the best care possible. It is because of this dedication in you that we will strictly follow the policies below regarding cancellations and rescheduling of appointments.

Please take the time to read these policies carefully and ask any questions that you may have.

A courtesy e-mail, text or phone call will be made as a reminder of your reserved time.

As a patient, it is your responsibility to keep all scheduled appointments. Failed appointments jeopardize the ability to provide optimal care to all patients. This office requires at least a 24 hour advance notice of any schedule changes. This is done by calling our office during normal business hours only at 214-731-0558. Our answering machine, e-mail system, or text does not accept these messages.

It is our policy to charge for a failed appointment. The fee is \$50.00 and will be charged to your account if you do not give the advanced notice required above or fail to arrive within 15 minutes of your scheduled appointment time.

Failing three scheduled appointments in a row or four appointments within a year will result in you being dismissed from the practice. In the event of a dismissal, at your written request, we will assist you in transferring your records. There is a \$50.00 charge to transfer records. All outstanding balances must be paid before records will be transferred.

Consent for Diagnostic Aids

You authorize the release of information necessary to process your dental claim(s). You authorize Fairway Dental to take any diagnostic aids necessary to evaluate, document and/or diagnosis your condition.

These shall include, but not limited to, radiographs, models, photographs, and video recordings. You further give Dr. Luis R. Perez permission to use such data in any future research, publication, or training purposes, if needed.

Financial Policy and Fee Estimates

Payment is expected at the time services are rendered.

Our office understands the value of insurance benefits and will happily file any and all primary dental claims. Insurance does not cover your entire bill. Insurance is meant to assist you financially. Your estimates, including deductible and patient portion, are given to us by your insurance company to provide you with a proposed treatment plan. *Any balance remaining is your direct responsibility.* This includes any non-covered services, yearly deductible or co-payments particular to your individual insurance plan. *It is important for you as the patient to understand that insurance is a contract between you the patient and your insurance carrier and not between you and your dentist.*

You will be given an estimate only and it may not reflect the real cost to be invested. Fees quoted are based on your proposed and accepted treatment plan. If during the course of treatment there is a change, fees will reflect these changes. The fee levels quoted on each plan of treatment will be honored for 90 days.

Please sign and date that you read, understand and agree to comply with the above stated diagnostic aid consent; cancellation, rescheduling, and financial policies and fee estimates.

Signature

Date

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Fairway Dental originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Fairway Dental is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations. Should Fairway Dental change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept/decline the terms of this consent.

Patient's Signature

Date

FOR OFFICE USE ONLY

- Consent received by _____ on _____.
- Consent refused by patient and treatment refused as permitted.
- Consent added to the patient's medical record on _____.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
- Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Herpes | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | | | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____