PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Patient Signature:_____ Date:_____

MEDICAL HISTORY

Patient Name: _____ Nickname: _____ Age: _____
Name of Physician/and their specialty: _____ Phone #: _____
Most recent physical examination: _____ Purpose: _____
What is your estimate of your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

DO YOU HAVE or HAVE YOU EVER HAD	YES	NO
1. Hospitalization for illness or injury _____	☐	☐
2. An allergic reaction to: **(Circle)**_____	☐	☐
Aspirin Ibuprofen Acetaminophen		
Codeine Penicillin Erythromycin		
Tetracycline Sulpha Local anesthetic		
Flouride Metals (nickel, gold, silver) Clindamycin		
Valuim or other sedatives Latex		
3. Are you taking any of these Medications? **(Circle)** _____	☐	☐
Tagamet® (cimetidine) Prilosec® (omeprazole)		
Cardizem® (diltiazem) Calan, Isoptin® (Verapamil)		
Pre-medication before dental treatment		
Serzone® (nefazodone) Dilantin® Tegretol		
Barbiturates (any) Biaxin® (clarithromycin)		
St. John's Wort, Kava-Kava		
P 4. Heart problems or cardiac stent within the last six months	☐	☐
5. History of infective endocarditis _____	☐	☐
6. Artificial heart valve, repaired heart defect _____	☐	☐
P 7. Pacemaker, implantable defibrillator _____	☐	☐
8. Artificial replacement joints (Year?)_ _____	☐	☐
9. Rheumatic or scarlet fever _____	☐	☐
P 10. High or Low blood pressure (circle) Your normal BP=____	☐	☐
11. A stroke _____	☐	☐
12. Anemia or other blood disorder _____	☐	☐
13. Prolonged bleeding due to slight cut (INR>3.5) _____	☐	☐
14. Emphysema, sarcoidosis _____	☐	☐
15. Tuberculosis _____	☐	☐
16. Asthma _____	☐	☐
17. Breathing, Sleeping problems, Snoring, Sinus (circle)____	☐	☐
18. Kidney disease _____	☐	☐
19. Liver disease _____	☐	☐
20. Jaundice _____	☐	☐
21. Thyroid, Parathyroid disease (circle) _____	☐	☐
22. Hormone deficiency _____	☐	☐
23. High cholesterol, taking statin drugs (circle) _____	☐	☐
P 24. Diabetes (HbA1c) _____	☐	☐
B 25. Stomach, duodenal ulcer (circle)_____	☐	☐
B 26. Digestive disorders, Gastric/acid reflux _____	☐	☐

	YES	NO
27. Osteoporosis/Osteopenia	☐	☐
28. Have you been treated w/ Bisphosphonate drug's? (circle)	☐	☐
(Fosamax®, Aredia®, Zometa®, Actonel®, Boniva, RANKL, Denosumab, Prolia)		
P 29. Arthritis _____	☐	☐
30. Glaucoma_____	☐	☐
31. Contact lenses _____	☐	☐
32. Head or neck injuries _____	☐	☐
33. Epilepsy, convulsions (seizures) _____	☐	☐
34. Neurologic problems (attention deficit disorder)_____	☐	☐
35. Viral infections and cold sores _____	☐	☐
36. Any lumps or swelling in the mouth _____	☐	☐
37. Hives, skin rash, hay fever(circle) _____	☐	☐
38. Venereal disease _____	☐	☐
39. Hepatitis (type ____) _____	☐	☐
40. HIV / AIDS _____	☐	☐
41. Tumor, abnormal growth _____	☐	☐
B 42. Radiation therapy _____	☐	☐
B 43. Chemotherapy _____	☐	☐
P 44. Emotional problems _____	☐	☐
45. Psychiatric treatment _____	☐	☐
B 46. Antidepressant medication _____	☐	☐
BP 47. Alcohol, Drug dependency (circle) _____	☐	☐
48. Please provide current weight: _____		
ARE YOU:		
49. Presently being treated for any other illness _____	☐	☐
50. Aware of a change in your general health _____	☐	☐
51. Taking medication for weight management (fen-phen)	☐	☐
52. Taking dietary supplement _____	☐	☐
53. Often exhausted or fatigued _____	☐	☐
54. Subject to frequent headaches _____	☐	☐
P 55. A smoker or smoked previously (circle) _____	☐	☐
56. Considered a touchy person _____	☐	☐
57. Often unhappy or depressed _____	☐	☐
58. Consume grapefruit juice, grapefruits or grapefruit extract?	☐	☐
59. MALE – prostate disorders: _____	☐	☐
60. FEMALE – Taking Birth Control pills _____	☐	☐
61. FEMALE – Pregnant _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____ _____

List all medications, supplements, and or vitamins taken in the last two years

Drug	Dosage	Purpose	Drug	Dosage	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

3/4/2011

URGENT CARE QUESTIONNAIRE

In order for us to provide the best diagnosis and treatment possible, please answer all questions to the best of your ability. Thank you.

On a scale of **1-10**, how important is your dental health to you? (1="Not very important," 10-"Extremely important.")			1-2-3-4-5-6-7-8-9-10	
On a scale of **1-10**, how would you rate your current dental health? (1="Very poor," 10="Excellent.")			1-2-3-4-5-6-7-8-9-10	
Who may we thank for referring you?			*Years*	*Months*
When was your last dental visit?				
Area of concern (please circle):	Upper Right	Lower Right	Upper Left	Lower Left
What is your immediate or main concern?				
PERSONAL HISTORY				
Are you fearful of dental treatment?			**YES**	**NO**
If "yes," how fearful on a scale of 1(somewhat) to 10 (extremely)?			1-2-3-4-5-6-7-8-9-10	
Have you ever had trouble getting numb, or reactions to local anesthetic?			**YES**	**NO**
Do you experience spontaneous pain (pain for no apparent cause or reason)?			**YES**	**NO**
On a scale 1-10, what is your current pain level? (1="Slightly sensitive," 10="Extremely painful.")			1-2-3-4-5-6-7-8-9-10	
GUM AND BONE				
Have you ever been treated for gum disease or been told you have lost bone around your teeth?			**YES**	**NO**
Do your gums bleed or are they painful when brushing, flossing or eating?			**YES**	**NO**
Do you have swelling inside or outside of your mouth?			**YES**	**NO**
TOOTH STRUCTURE				
Do your parents or siblings have "bad teeth"?			**YES**	**NO**
Does the amount of saliva in your mouth seem too little (dry mouth) or do you have difficulty swallowing food?			**YES**	**NO**
Are any teeth currently sensitive to hot, cold, biting, brushing or sweets (circle all that apply)?			**YES**	**NO**
Do you have a cracked filling, broken, chipped or cracked tooth (circle all that apply)?			**YES**	**NO**
BITE, CHEWING AND JAW JOINT				
Do you have problems with your jaw joint: pain, sounds, limited opening, locking, popping (circle all that apply)?			**YES**	**NO**
Is today's problem affecting your ability to eat or chew normally?			**YES**	**NO**
Do you clench or grind your teeth?			**YES**	**NO**
Do you have problems sleeping (i.e. restlessness), wake up with pain, headache or an awareness of your teeth?			**YES**	**NO**
Do you or have you ever worn a bite appliance (Niteguard, Splint)?			**YES**	**NO**
SMILE CHARACTERISTICS				
Have you felt unhappy, uncomfortable or self-conscious about the appearance of your teeth?			**YES**	**NO**
Is there anything about the appearance of your teeth that you would like to change?			**YES**	**NO**
If "yes," what would you like to change?				

Patient's Name:_____

Patient's Signature:_____

Date:_____

Doctor's Signature:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP).
This Notice describes how your medical information may be used and disclosed by us.
It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.
If you have any questions about this Notice, the name and phone number or our contact person is listed on this page.

Effective Date of this Notice	**October 1, 2003**
Phone Number	**(559) 435-3113**

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's ***NOTICE OF PRIVACY PRACTICES*.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this ***NOTICE OF PRIVACY PRACTICES*** should it be amended, modified, or changed in any way."

_____

Patient or Representative Name (Please Print)

_____ _____

Patient or Representative Signature **Date**

☐ Patient refused to sign ☐ Patient was unable to sign because _____

Financial Interest Disclosure

Under California law, I (Dr. Mirelez) am required to inform you, that I have a financial interest in **Dental Imaging Solutions,** to which I may refer you for services. There may be other organizations from which you may obtain these services. Should I decide to refer you to **Dental Imaging Solutions,** you should know that there may be alternative locations to acquire similar requested services.

Acknowledgement of Publicity Materials

[ ] **I authorize** the taking of clinical photographs and videos and their use for scientific, educational and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold Mirelez Wellness Dental harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

[ ] **I do NOT authorize** Mirelez Wellness Dental to take or share photographs and/or videos.

_____

Signature **Date**

J. ART MIRELEZ JR., DDS, FICOI, FAGD
5492 N. PALM AVENUE • FRESNO, CA 93704 • **PHONE:** 559.435.3113 • **FAX**: 559.435.5785
EMAIL: DRMIRELEZ@MIRELEZDENTAL.COM • **WEB:** WWW.MIRELEZDENTAL.COM

OnCall Dental &URGENT CARE
559.900.2332
OnCallDentalFresno.com

Financial Policy

To maintain operations and prevent potential misunderstandings, we ask you to accept and adhere to the following financial policy for dental treatment for yourself or any family member:

PATIENTS WITH DENTAL INSURANCE:

We understand that dental insurance plays a role in helping defray some of the costs of dental care. However, we would like to share with you the following facts about dental insurance.

Dental insurance often will not pay for everything. It is meant only to **assist** in paying for your dental care. Dental insurance plans have no correlation to actual patients' needs. As such, many routine and necessary dental services are not covered, even though you may need those services. Our responsibility is to provide you with the best care and treatment to meet your needs, not to match your care to insurance plan limitations. Many plans pay much less than you might expect. The benefits your plan pays for are largely determined by how much your employer or you pay in premiums for the plan. We are happy to submit your claims and help you to receive the maximum benefits due to you, but please understand that **we do not accept responsibility for collecting an insurance claim, or negotiate disputed claims. *You remain responsible for payment for unpaid services.***

OPTIONAL PAYMENT TERMS:

- **Discount for Cash (no insurance):** We also provide a **5%** discount for restorative dental services when paid with cash or check, ***orthodontic and cosmetic treatment excluded***
- **In-Office Complete Dental Plan:** The complete dental plan (VIP) includes two complimentary cleanings, all exams and x/rays within the plan year, and you will receive a **20%** discount for restorative dental services. (Please note that discount will differ if financing is utilized) ***orthodontic and cosmetic treatment excluded***
- **Term Loan:** By arrangement with *Care Credit* and *Sunbit,* we offer our patients an interest-free term loan with no down payment, no annual fee, and no prepayment penalty (subject to approval). You can complete the provided "*Payment Plan Credit Application*" or you can visit www.CareCredit.com or **www.sunbit.com** to see which plan works best for you. You can find additional information at www.Mirelezdental.com.

APPOINTMENT FEE:

For each appointment, a specific amount of time and material is reserved especially for you. We strongly encourage our patients to keep their appointments. If you must change your appointment, we require a **48 business hour notice. Appoint fees depend on appointment type:**

- **Hygiene appointments:$100 per hour.**
- **Dr. Appointments:$200 per hour.**
- **Sedation appointments: $1000.00.(Sedation appointments REQUIRE 5 day advance notice.**

CONFIRMATION POLICY: We routinely confirm appointments via phone and or text. If we are unable to reach you,we may remove your appointment from the schedule and ask you to reschedule

COLLECTION POLICY:

Payments are expected at the time services are rendered. We accept cash, checks, debit cards, and all major credit cards. You will be responsible for a $75.00 bookkeeping fee if your account is assigned to a third party for collection. Should suit be commenced to enforce any of the terms of this agreement, you shall pay all attorney's fees and costs. The Court of jurisdiction shall be Fresno County. You hereby grant the right to verify employment or run a credit report to assess your ability to fulfill your financial obligation to this agreement. If communication by phone is necessary, you grant permission to the office, or our assigns, to contact you by phone. If you are unavailable, and a recording device is operable, a message may be left providing a name and phone number.

Patient Name (Please Print)_____ Patient Signature_____

Date _____