RIVIERA SMILES
advanced adult and children's dentistry

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To assist us in serving you, please complete the following confidential form.

Patient's last, first name _____ Preferred name _____ DOB _____

If minor, parents' full names _____

Social security # _____Cell phone _____Other phone_____

Email address _____ Emergency contact _____

Mailing address _____ City _____ State _____ Zip_____

If using Dental insurance: Company _____ Group # _____ Ins. ID # _____

Insured's name _____ Insured's DOB _____ Insured's employer _____

How did you hear about us? _____

How do you prefer to be contacted? ☐ Phone ☐ Email ☐ Either/Both

Health History

Days a week you engage in exercise _____ Time you spend exercising each session _____

Physical activity (circle) Light (no sweating) Moderate (light sweating) Heavy (sweating)

Glasses of water you drink daily _____ Hours of sleep you get a night _____ Do you snore? _____

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

- ☐ Thyroid problems
- ☐ Cancer or tumor
- ☐ Cancer surgery / Radiation / Chemotherapy
- ☐ Heart ailment / Angina
- ☐ Heart murmur / Mitral valve prolapse / Heart Defect
- ☐ Rheumatic fever or heart disease
- ☐ Artificial joint or valve
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Smoke / chew tobacco
- ☐ Tuberculosis / Lung problems
- ☐ Kidney disease
- ☐ Hepatitis / Liver disease
- ☐ Alcoholism
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Neurologic condition
- ☐ Epilepsy / Seizures / Fainting spells
- ☐ Emotional condition
- ☐ Arthritis
- ☐ Problems breathing through nose
- ☐ Hospitalized for any reason
- ☐ Any surgery _____
- ☐ Herpes / Cold sores
- ☐ AIDS / HIV positive
- ☐ Migraine headaches / Frequent headaches
- ☐ Anemia / Blood disorders
- ☐ Abnormal Bleeding after extractions, surgery, trauma
- ☐ Hayfever / Sinus trouble
- ☐ Allergies / Hives _____
- ☐ Asthma
- ☐ Other _____

Please Print Name (relation to patient) Signature Date

Health History (continued)

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Latex materials
- ☐ Penicillin or other antibiotics
- ☐ Local anesthesia (Novocain)
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Other: _____

Are you taking or have you ever taken any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics or sulfa drugs
- ☐ High blood pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin, Orinase, or other diabetes drug
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine
- ☐ Other: _____

Women:

- ☐ May be pregnant. Expected due date _____
- ☐ Taking hormones or contraceptives_____

Primary care Physician's name _____

Any conditions not mentioned above:_____

Dental History:

Frequency of tooth brushing:(circle) less than 7/week 7-14/week more than 14/week

Frequency of flossing:(circle) Never A few times a month A few times a week Daily

Do you currently have pain in your mouth?	Yes	No
Do your gums bleed?	Yes	No
Do you grind or clench your teeth or jaw?	Yes	No
Would you like to whiten your teeth?	Yes	No

When was the last time you visited a dentist? _____

What was the reason for your last visit? _____

Last time you had xrays? _____ Last time you had dental work?_____

Name and city from your previous dentist: _____

Reason why you left your previous dental office: _____

_____

Please Print Name (relation to patient) Signature Date

GENERAL CONSENT

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

- 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.
- 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.
- 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.
- I will pay in full all costs of treatment regardless of insurance coverage according to our financial policy. I understand that even if an insurance estimate is given or a procedure has been pre-approved, I am responsible for all costs.
- 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 understand taking pictures and/or any type of recording within the premises of Riviera Smiles is not allowed without prior written consent from Dr. Ana R. Martinez.
- 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 about which I have questions.

HANDLE ME WITH CARE

Please select all that apply to you:

- ☐ I am scared to be here
- ☐ I gag easily
- ☐ I feel out of control when I am in a dental chair
- ☐ I have not been to the dentist for a while and am uncomfortable about what you will say or think
- ☐ I know I have bad habits that cause harm to my dental health. I am afraid I might not be able to break them
- ☐ Pain relief is a top priority to me
- ☐ My teeth are very sensitive
- ☐ I do not like shots, or I have had a bad reaction to shots
- ☐ Please tell me what I need to know about my mouth so I can make an informed decision
- ☐ I do not like cotton in my mouth
- ☐ I hate drilling, picking or scraping noises
- ☐ I do not like dental office smells
- ☐ I want to know costs up front. No money surprises
- ☐ I have difficulty remembering what I hear while in a dental chair
- ☐ I have problems with my back
- ☐ I do not like being left alone in the treatment area
- ☐ I have health problems and questions to discuss
- ☐ I do not like the chair being tipped back too far
- ☐ I do not like to see dental instruments
- ☐ I need to talk first, before sitting in the dental chair
- ☐ Other concerns:_____

_____

Please Print Name (relation to patient) Signature Date

FINANCIAL POLICY AND AGREEMENT

Appointment cancellation and no-show policy and fee

We feel that our patients' time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you. Please call our office promptly if you need to cancel or reschedule an appointment. Any appointment(s) not canceled or rescheduled **2 business days in-advance** is subject to a **$75 late cancellation fee**.

A no-show is an appointment that was not canceled in advance. A no show for a scheduled appointment will therefore result in a fee of **$50 for every half hour** of scheduled appointment time.**Repeated cancellations or missed appointments will result in loss of future appointment privileges.**

Billing & insurance

We accept most insurance plans, If you wish, we can also provide you with a pre-treatment estimate that can help you determine how much will be covered by your plan.We work hard to make dental care affordable and to ensure that you are getting the most coverage possible from your insurance company. We also offer credit and flexible financing options for patients without insurance or whose procedures are not covered.

It is the patient's (or responsible party) responsibility to understand whether insurance has limits on the doctors you can see, or the services you can receive. Your insurance is a contract between you and your insurance company. **You (or responsible party) are responsible for the entire cost of treatment at the time of the service regardless of insurance coverage.** We will gladly document your insurance paperwork as a courtesy and help you maximize your benefits. Payment will then be sent to you directly from the insurance.

Your insurance company makes final determination once treatment is completed and the claim is submitted. Policies can change, and employers can switch providers or levels of coverage, which can affect the amount of your bill. If you have questions about what your responsibility might be, our staff will be happy to submit a pre-treatment estimate to your insurance company to provide an idea of your out-of-pocket costs.

Payment

Please feel free to discuss your individual financial needs with us prior to the scheduled appointment so that payment arrangements can be made. If payment in full is made in advance of treatment, we extend a 5% cash accounting reduction courtesy on the total fees.
ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment. We accept payment in the form of cash, check and major credit cards Visa, MasterCard and American Express). If you need to spread out payments, We implement flexible payment plans upon approval through Care Credit®. Approval must be received prior to treatment date.

There is a $30 processing charge for **non-sufficient funds** or **returned checks.** There is a fee for canceling a credit card transaction, this fee is 8% of the amount charged to the credit card. We have a **no refund** policy. We reserve the right to determine whether special circumstances justify a refund in the form of an adjustment to the patient's account. Past due accounts will be subject to a charge of 1.5% per month interest. The patient is responsible for all collection costs incurred by the dental office.

Parents not accompanying their child to an appointment must make prior arrangements for payment (cash, check or credit card authorization). If someone other than yourself is responsible for the bill, such as a divorced spouse, we will provide a statement that you can use for reimbursement purposes. Payment is expected from the person who brings the child in for services, and we do not get involved with billing other persons or waiting for the conclusion of court cases.

Copies of Your Dental Records and X-rays

If you want copies for yourself or to send to another healthcare provider, we ask that you put the request in writing. Once we receive your written request, we will make every attempt to have the records available within three business days. Depending on the size and format(s) of the records requested, a fee of $20.00 may be applied.

Please Print Name (relation to patient) Signature Date