ADVANCED DENTAL CARE OF STX

ROEL VALADEZ, JR., D.D.S.

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST

☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ CHILD ☐ OTHER _____

MAILING ADDRESS _____
STREET CITY STATE ZIP CODE

SOC. SEC. # _____ BIRTHDATE _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____ OTHER PHONE _____

OCCUPATION _____ EMPLOYER NAME _____

EMPLOYER ADDRESS _____
STREET CITY STATE ZIP CODE

EMAIL ADDRESS _____ SPOUSE OR PARENT'S NAME _____

EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT _____ PHONE _____

RESPONSIBLE PARTY ☐ CHECK IF SAME AS ABOVE

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT ☐ OTHER _____

MAILING ADDRESS _____
STREET CITY STATE ZIP CODE

SOC. SEC. # _____ BIRTHDATE _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____ OTHER PHONE _____

OCCUPATION _____ EMPLOYER NAME _____

EMPLOYER ADDRESS _____
STREET CITY STATE ZIP CODE

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

PROVIDER/REFERRAL INFORMATION

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? (CHECK MULTIPLE IF APPLICABLE)

☐ ANOTHER PATIENT ☐ OTHER DENTAL OFFICE ☐ OFFICE WEBSITE ☐ OUTDOOR BILLBOARD ☐ FACEBOOK

☐ INTERNET SEARCH ☐ YELLOW PAGES ☐ NEWSPAPER ☐ WORK ☐ OTHER _____

NAME OF PERSON/ENTITY REFERRING YOU TO OUR PRACTICE: _____

_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

ADVANCED DENTAL CARE OF STX

ROEL VALADEZ, JR., D.D.S.

PATIENT'S NAME _____ DATE _____
FIRST MI LAST

WHY HAVE YOU COME TO SEE US TODAY? _____

WHEN WAS YOUR LAST DENTAL VISIT? _____ WHAT WAS DONE THEN? _____

_____

PREVIOUS DENTIST (NAME AND LOCATION – OPTIONAL) _____

HAVE YOU HAD FULL MOUTH X-RAYS OR A PANORAMIC FILM TAKEN? ☐ YES ☐ NO

WHEN, WHERE? _____

HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ HOW OFTEN DO YOU FLOSS YOUR TEETH? _____

PLEASE CHECK ONE BOX

	YES	NO
DO YOUR GUMS BLEED WHILE YOU ARE BRUSHING OR FLOSSING?	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR 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 ANY 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 OPENING OR CLOSING?	☐	☐
DIFFICULTY IN CHEWING	☐	☐

	YES	NO
DO YOU HAVE FREQUENT HEADACHES?	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH?	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	☐	☐
DO YOU REGULARLY HAVE A DRY MOUTH?	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)?	☐	☐
HAVE YOU WORN A NIGHT GUARD, BITE PLATE OR OTHER APPLIANCE?	☐	☐
HAVE YOU HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
HAVE YOU HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	☐	☐
DO YOU WEAR DENTURES OR PARITALS?	☐	☐
IF YES, DATE OF PLACEMENT? _____		

IF YOU COULD CHANGE <u>ANYTHING</u> ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

_____

_____

_____

NOTES (OFFICE USE ONLY): _____

_____

_____

DENTAL HISTORY

ADVANCED DENTAL CARE OF STX

ROEL VALADEZ, JR., D.D.S.

PATIENT'S NAME _____ DATE _____
FIRST MI LAST

PLEASE CHECK ONE BOX WHERE INDICATED

	YES	NO
ARE YOU IN GOOD HEALTH?	☐	☐
HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?	☐	☐
DATE OF YOUR LAST PHYSICAL EXAM: _____		
PHYSICIAN'S NAME _____		
ADDRESS _____		
PHONE NO. _____		
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR ILLNESS?	☐	☐
PLEASE EXPLAIN. _____		
ARE YOU TAKING ANY MEDICINE(S), INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICINE(S) ARE YOU TAKING? _____		

	YES	NO
HAVE YOU EVER TAKEN FEN-PHEN OR REDUX?	☐	☐
HAVE YOU EVER TAKEN BISPHOSPHONATE DRUGS (FOSAMAX, BONIVA, ACTONEL, RECLAST, ZOMETA, ACLASTA, AREDIA, BENEFOS, DIDRONEL, ETC.) FOR OSTEOPOROSIS OR CHEMOTHERAPY?	☐	☐
DO YOU HAVE PROLONGED BLEEDING OR BRUISE EASILY?	☐	☐
HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	☐	☐
HAVE YOU HAD A RECENT WEIGHT LOSS?	☐	☐
DO YOU USE TOBACCO?	☐	☐
DO YOU DRINK ALCOHOL?	☐	☐
DO YOU NOW OR HAVE YOU EVER USED CONTROLLED SUBSTANCES?	☐	☐
DO YOU WEAR CONTACT LENSES?	☐	☐
WOMEN ONLY:		
ARE YOU PREGANT OR THINK YOU MAY BE PREGNANT?	☐	☐
ARE YOU NURSING?	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVES, OR SLEEPING PILLS	☐	☐
CODEINE	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G. NICKEL, MERCURY, ETC.)	☐	☐
LATEX	☐	☐
OTHER (PLEASE LIST) _____		
DO YOU NOW HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
HIVES OR SKIN RASH	☐	☐
GLAUCOMA	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
BACK PROBLEMS	☐	☐
TOTAL JOINT OR HEART VALVE REPLACEMENT	☐	☐
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
CONGENITAL HEART PROBLEM OR HEART MURMUR	☐	☐
HEART ATTACK	☐	☐
CHEST PAIN, PRESSURE, OR ANGINA	☐	☐
PACEMAKER AND/OR DEFIBRILLATOR	☐	☐
HEART SURGERY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
STROKE	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
TONSILLITIS	☐	☐
SEASONAL ALLERGIES OR SINUS TROUBLE	☐	☐

	YES	NO
SHORTNESS OF BREATH	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA	☐	☐
CHRONIC BRONCHITIS OR EMPHYSEMA (COPD)	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
EATING DISORDERS	☐	☐
STOMACH ULCER OR REFLUX (GERD)	☐	☐
THYROID PROBLEMS	☐	☐
LOW BLOOD SUGAR (HYPOGLYCEMIA)	☐	☐
DIABETES	☐	☐
EXCESSIVE THIRST	☐	☐
PAINFUL OR FREQUENT URINATION	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
KIDNEY TROUBLE	☐	☐
DIALYSIS TREATMENT	☐	☐
ANEMIA	☐	☐
AIDS OR HIV INFECTION	☐	☐
PROBLEMS WITH YOUR IMMUNE SYSTEM	☐	☐
STEROID TREATMENT	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ALTERED SENSATION OR NERVE PAIN (PARESTHESIA, NEURALGIA, FIBROMYALGIA)	☐	☐
PSYCHIATRIC CARE FOR ANXIETY, DEPRESSION	☐	☐
CHEMICAL DEPENDENCY	☐	☐
TUMORS OR CANCER	☐	☐
CHEMOTHERAPY OR RADIATION THERAPY	☐	☐
DO YOU HAVE ANY ADDITIONAL DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE?	☐	☐

I certify that I have answered all questions on this form truthfully and completely. Any and all questions I had about the inquiries above have been answered to my satisfaction. I will not hold Advanced Dental Care of South Texas or its doctors, hygienists, or staff responsible for any errors or omissions I have made.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

MEDICAL HISTORY

ADVANCED DENTAL CARE OF STX

ROEL VALADEZ, JR., D.D.S.

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
(HIPPA)

I, _____ HAVE RECEIVED A COPY OF ADVANCED DENTAL CARE OF
NAME OF PATIENT

SOUTH TEXAS NOTICE OF PRIVACY PRACTICES (HIPPA).

_____ Date: _____ Relationship to Patient: _____
Signature of Patient, Parent or Guardian

STAFF WILL FILL OUT THIS SECTION IF PATIENT'S SIGNATURE NOT OBTAINED

OUR OFFICE MADE A GOOD FAITH EFFORT TO OBTAIN AXKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT IT COULD NOT BE OBTAINED FOR THE FOLLOWING REASON:

- ☐ PATIENT REFUSED TO SIGN.
- ☐ EMERGENCY SITUATION PREVENTED US FROM OBTAINING THE PATIENT'S SIGNATURE.
- ☐ LANGUAGE BARRIERS KEPT US FROM OBTAINING THE PATIENT'S SIGNATURE.
- ☐ OTHER _____

_____ Date: _____
Signature of Advanced Dental Care of STX Staff

ADVANCED DENTAL CARE OF STX

ROEL VALADEZ, JR., D.D.S.

FINANCIAL POLICY/TRUTH IN LENDING

OUR CENTRAL GOALS ARE TO PROMOTE YOUR OVERALL HEALTH AND TO ASSIST YOU IN AFFORDING THE QUALITY DENTISTY YOU DESERVE. IN ACCORDANCE WITH THE FEDERAL TRUTH-IN-LENDING WHICH REQUIRES ALL DOCTORS TO GIVE THEIR PATIENT INFORMATION IN CONNECTION WITH EXTENSION OF CREDIT, PLEASE BE ADVISED OF THE FOLLOWING POLICIES WHICH APPLY IN OUR OFFICE. THE RESPONSIBLE PARTY AGREES TO THE FOLLOWING:

1. TO PAY THE DOCTOR AT THE TIME TREATMENT OR SERVICE IS RECEIVED, OR BY PREVIOUS ARRANGEMENTS.
    - THE OFFICE ACCEPTS THE FOLLOWING FORMS OF PAYMENT:
        - CASH
        - PERSONAL CHECKS
        - DEBIT CARDS
        - MAJOR CREDIT CARDS

    - THE FOLLOWING PAYMENT OPTIONS ARE ALSO AVAILABLE TO YOU:
        - IN CASES REQUIRING LABORATORY WORK, IT MAY BE POSSIBLE TO PAY FOR TREATMENT WITH 50% DUE ON THE DAY OF INITIAL TREATMENT AND THE BALANCE PAID ON THE DAY OF COMPLETION OF THE WORK. THE OFFICE MANAGER WILL DISCUSS THESE PAYMENT OPTIONS WITH YOU.
        - FOR PATIENTS WHO WISH TO PAY FOR TREATMENT OVER AN EXTENDED PERIOD OF TIME, WE OFFER A PAYMENT PLAN THAT IS ADMINISTERED BY AN INDEPENDENT COMPANY (CARE CREDIT OR LENDING CLUB). THE OFFICE MANAGER WILL PROVIDE YOU WITH ALL THE DETAILS.

2. WE ARE PLEASED TO PROVIDE OUR PATIENTS WITH ASSISTANCE IN FILING CLAIMS TO THEIR **PRIMARY** DENTAL INSURANCE COMPANY. WE ACCEPT **MOST** DENTAL INSURANCES; HOWEVER, WE ARE NOT PREFERRED OR IN-NETWORK PROVIDERS WITH ANY INSURANCE COMPANY. EACH PLAN UTILIZED IN OUR OFFICE HAS DIFFERENT PERCENTAGES, DEDUCTIBLES, MAXIMUMS, PROCEDURES COVERED, AND VARYING FEES THE PLAN WILL ALLOW. WE WILL DO OUR VERY BEST TO MAKE **AS CLOSE A CALCULATION AS POSSIBLE** OF WHAT YOUR INSURANCE PLAN WILL COVER, FILE YOUR CLAIM ON YOUR BEHALF, AND PROVIDE THE COMPANY WITH ALL REASONABLE SUPPORTING DOCUMENTATION TO COMPLETE THE CLAIMS PROCESS. YOUR INSURANCE COMPANY WILL THEN REMIT PAYMENT TO OUR OFFICE FOR THE COVERED AMOUNT THEY DETERMINE BASED UPON YOUR SPECIFIC PLAN. AS YOUR PORTION OF THE TREATMENT PLAN FEE IS OUR **BEST ESTIMATE**, PATIENTS WILL OCCAISIONALLY HAVE A CREDIT OR BALANCE DUE FOLLOWING CLAIM PROCESSING. ANY CREDITS WILL BE RETURNED TO THE PATIENT AT THEIR REQUEST OR APPLIED TO FUTURE SERVICES.

3. IN THE EVENT MY INSURANCE COMPANY DOES NOT COVER THE ENTIRE BALANCE OF THIS ACCOUNT WITHIN 30 DAYS FROM THE DATE OF SERVICE, **I AGREE TO PAY THE BALANCE IN FULL WITHIN 60 DAYS FROM THE DATE OF SERVICE**, OR BY PREVIOUS ARRANGEMENTS.

4. A $25.00 SERVICE CHARGE WILL BE APPLIED TO ALL RETURNED CHECKS.

5. I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Patient and Minor child

Photograph/ Video/ Electronic Image Consent Form

The purpose of this consent form is to obtain permission for yourself or parental/guardian consent for your minor child with the express purpose of appearing in videos, photographs or other electronic imaging for documenting patient achievements, online contests, in-office message boards or community involved events hosted by Advance Dental Care of South Texas (ADC).

The photographs and/ or video may be images taken by office staff or supplied by patients or parent/ guardian with the understanding they may be visible on social media or marketing tools for ADC. Throughout the year our office hosts varying ongoing events on our facebook page or in-office that involve community participation. We would love to have you and your minor children participate and get recognition in a public forum. Under no circumstances will these images/ videos release any personally identifying information other than the patient's face, first name (and possibly age for children).

Please check one of the following choices:

___ I GRANT permission for photo/video/ electronic image(s) that includes myself or my minor pchild to be shared by Advanced Dental Care of South Texas in a public forum, including online social media.

___ I DO NOT GRANT permission for my or my minor child's image to be shared by Advanced Dental Care of South Texas.

Patient Name (please print)

_____

Name of Parent/ Guardian (please print)

_____

Signature of Parent/ Guardian

_____

Date

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*This consent form remains in perpetuity unless rescinded in writing by parent/ guardian or patient reaches age of consent and wishes to no longer participate.