Patient Information

Name_____ Date of Birth _____

Social Security No. _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. _____ Email _____

Check Appropriate Box:

- ○ Minor
- ○ Single
- ○ Married
- ○ Divorced
- ○ Widowed
- ○ Separated

Whom may we thank for referring you?_____

Person to contact in case of emergency: _____ Telephone No. _____

Relationship to patient_____

Patient Medical History

Are you under medical treatment now? If yes, please indicate the name of the doctor and office telephone number: _____ ○ Yes ○ No

Have you been hospitalized for any serious operation or illness in the past 5 years? If yes, please explain:_____ ○ Yes ○ No

Are you taking any medications, including non-prescription medicine? If yes, what medications are you taking? _____ _____ _____ ○ Yes ○ No

Have you ever taken Fen-Phen/Redux? ○ Yes ○ No

Have you ever taken Viagra, Revatio, Cialis, or Levitra? ○ Yes ○ No

Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing biphosphonates? ○ Yes ○ No

Are you on a diet? ○ Yes ○ No

Do you consume tabaco? ○ Yes ○ No

¿Are youallergic toany of thefollowing?

Aspirin		
Metal	○ Yes	○ No
	○ Yes	○ No
Iodine	○ Yes	○ No
Penicillin	○ Yes	○ No
Latex/Rubber	○ Yes	○ No
Sulfa	○ Yes	○ No
Codeine	○ Yes	○ No
Local Anesthesia	○ Yes	○ No
EuthanasiaMedications	○ Yes	○ No
Sedatives	○ Yes	○ No
Other: _____		

WomenOnly:

Are you pregnant?	○ Yes	○ No
¿Are you trying to conceive?	○ Yes	○ No
¿Are youbreastfeeding?	○ Yes	○ No
¿Are youdrinkingcontraceptives?	○ Yes	○ No

Do you have or have had any of the following?

AIDS/HIV	○ Yes	○ No	HeartPacemaker	○ Yes	○ No
Alzheimer's	○ Yes	○ No	HeartTrouble/Disease	○ Yes	○ No

Anaphylaxis	○ Yes ○ No	Sexually Transmitted Disease	○ Yes ○ No
Anemia	○ Yes ○ No	Hemofilia	○ Yes ○ No
Angina	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	High Cholesterol	○ Yes ○ No
Artificial HeartValve	○ Yes ○ No	Hives/Rash	○ Yes ○ No
ArtificalJoint	○ Yes ○ No	Hypoglycema	○ Yes ○ No
Asthma	○ Yes ○ No	KidneyProblems	○ Yes ○ No
BloodDisease	○ Yes ○ No	Leukemia	○ Yes ○ No
BloodTransfusion	○ Yes ○ No	LiverDisease	○ Yes ○ No
BreathingProblems	○ Yes ○ No	LowBloodPressure	○ Yes ○ No
BruiseEasily	○ Yes ○ No	Lung Disease	○ Yes ○ No
Cancer	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No
ChestPains	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Cold Sores/FeverBlisters	○ Yes ○ No	Pain in JawJoints	○ Yes ○ No
CongenitalHeartDisorder	○ Yes ○ No	ParathyroidDisease	○ Yes ○ No
Convulsions	○ Yes ○ No	PsychiatricCare	○ Yes ○ No
Hepatitis	○ Yes ○ No	RespiratoryProblems	○ Yes ○ No
Cortisone	○ Yes ○ No	Radiation/Chemotherapy	○ Yes ○ No
Diabetes	○ Yes ○ No	RecentWeightLoss	○ Yes ○ No
DrugAddiction	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
EasilyWinded	○ Yes ○ No	RheumaticFever	○ Yes ○ No
Emphysema	○ Yes ○ No	Rheumatism	○ Yes ○ No
Epilepsy/Seizures	○ Yes ○ No	ScarletFever	○ Yes ○ No
ExcessiveBleeding	○ Yes ○ No	SickleCellDisease	○ Yes ○ No
ExcessiveThirst	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
FaintingSpells/Dizziness	○ Yes ○ No	Spinabifida	○ Yes ○ No
FrequentlyTired	○ Yes ○ No	StomachDisease	○ Yes ○ No
FrequentCough	○ Yes ○ No	Intestinal Disease	○ Yes ○ No
FrequentDiarrhea	○ Yes ○ No	ThyroidProblems	○ Yes ○ No
FrequentHeadaches	○ Yes ○ No	Tonsilities	○ Yes ○ No
Herpes	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Glaucoma	○ Yes ○ No	Tumor sor Growths	○ Yes ○ No
Hay Fever	○ Yes ○ No	Ulcers	○ Yes ○ No
HeartAttack/Failure	○ Yes ○ No	VenerealDisease	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No

Other: _____

Comments:

_____

_____

_____

PatientSignature: _____

Signature of Parent/Legal Guardian: _____

Date: _____

GENERAL DENTISTRY INFORMED CONSENT

Flores Dental Group
11890 SW 8th St, Suite #300
Miami, FL. 33184
Tel: (305) 485-0072
Fax: (305) 485-0080

Please read the following information and sign at the bottom of the last page.

PHOTOS AND IMAGES:

Unless otherwise indicated, I hereby give my consent to take photographs, slides, and videotape and/or computer images of face, jaw, and teeth. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or advertisements to promote cosmetic dentistry. I understand that laboratories for fabrication of crowns, veneers, and bridges may use some of these images for dentures and these images will become part of my dental record. I do not expect compensation, financial or otherwise, for the use of these images. I understand that the information disclosed under this authorization may be subject to re-disclosure and no longer protected by the federal privacy regulation. I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. However, the refusal may cause the result of the treatment not to be the best possible. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization.

X-RAYS:

Unless otherwise indicated, I hereby give my consent to take x-rays. I understand the benefits and advantages for the x-rays as an additional diagnostic tool for treatment planning. X-rays reveal undersurface details that are not visible to the naked eyes. Even though x-rays may not reveal all vital information. I understand that, without an x-ray, there are details and pathology may be missed to aide in making an accurate diagnosis. In refusing the recommended x-rays, I take full responsibility of any undiagnosed interproximal cavities (cavities in between the teeth); any undiagnosed tumors, cysts, or abscessed teeth found in the oral cavity, and bone loss, which may be noted on the dental x-rays. Bone loss is monitored on x-rays because it occurs with Periodontitis (Gum Disease), which can result in loss of teeth if not diagnosed and treated. The standard regimen for taking dental x-rays is once every three to five years for a Full Mouth Series, and every 6 months to one year for the bitewing x-rays which are taken in between the dates of the Full Mouth Series and /or your twice-a-year check-ups.

DRUGS & MEDICATIONS:

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

CHANGES IN TREATMENT PLAN:

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures, I give my permission to the Dentist to make any/all changes and additions as necessary.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or the professional corporation is responsible for my dental treatment. I hereby authorize any of the doctors, hygienist, or dental auxiliaries of Flores Dental Group by Dr. Joan M. Flores to proceed with and perform the dental restoration and treatments for the patient named below. I understood that this is only an estimate and subject to modification depending on unforeseen or previously undiagnosed circumstances that may arise during the course of treatment. I have read, understood, and agreed to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original forever. I am of legal age and legally competent to make this assignment.

Patient Name: _____

Patient Signature: _____

Signature of Parent/Legal Guardian: _____

Date: _____

Notice of Privacy Practice

Flores Dental Group
11890 SW 8th St, Suite #300
Miami, FL. 33184
Tel: (305) 485-0072
Fax: (305) 485-0080

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GETACCESS

TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for healthcare operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the
- federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or
- for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates' who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice. Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). Bylaw, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that] have received a copy of the Notice of Privacy Practices. I give Flores Dental Group permission to use my health information to treat me as outlined above.

Patient Name: _____

Patient Signature: _____

Signature of Parent/Legal Guardian: _____

Date: _____

Under current Florida Law, we have the right to refuse to treat you if you do not sign this form. We will inform you if you choose that option.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Flores Dental Group
11890 SW 8th St, Suite #300
Miami, FL. 33184
Tel: (305) 485-0072
Fax: (305) 485-0080

Patient Name: _____

Patient DOB: _____

Patient Phone Number: _____

Patient Address: _____

I authorize Flores Dental Group to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:

_____

2. To whom may the information be released [individual or entity authorized to receive my health information]:

_____

3. Purpose for disclosure:

_____

4. Expiration date or event relating to the individual or purpose for the release:

_____

I understand that if the person(s) or entity(ies) that receive my information is/are not a health care provider or provider not covered by the federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Dr. Joan Flores and his staff from all liability arising from this disclosure to my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization.

I understand that I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain treatment, payment, or my eligibility for benefits.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note to the office information above telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____

Signature of Parent/Legal Guardian: _____

Date: _____

SIGNATURE ON FILE

Flores Dental Group
11890 SW 8th St, Suite #300
Miami, FL. 33184
Tel: (305) 485-0072
Fax: (305) 485-0080

I, _____ (Patient Name), understand that my signature is necessary for my doctor's office to:

- Process all insurance submissions (i.e. claims, referrals).
- To ensure payment for services rendered.
- To release medical/dental information to insurance companies.
- To release medical/dental information to other medical/dental providers (i.e. referrals, medical clearance), when necessary, for my treatment.

By signing this form, I authorize my doctor and his staff to use this form on all of my insurance submissions. I authorize the release of my information to all of my insurance carriers. I authorize my doctor and his staff to act as my agent in helping me obtain payment for my treatments from my insurance carrier. I authorize payment directly to my doctor. I understand that I am responsible for my bill. I authorize the release of my information to other medical/dental providers. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature: _____

Signature of Parent/Guardian: _____

Date: _____

CANCELLATION POLICY

Patient Name: _____

Please take note of our new office policy:

Missing appointments have become an increasing financial and logistical burden, threatening the health of our practice. Though our inclination is to forgive these mistakes, we simply cannot continue as we have. At the moment of your consent [below], the following will hold:

- If the patient needs to reschedule their appointment, they will be allowed this courtesy ONCE. Please call at least 48 hours in advance to let us know of this circumstance.

- If a patient misses this second appointment, there will be $25 non-refundable fee. All fees must be paid before scheduling your next appointment.

We understand that circumstances beyond your control may arise, causing you to miss your appointment. In this case, please call as soon as you can so that we can fill your appointment with someone who needs care.

Please sign below to confirm that you have read, understood, and agree with the above mentioned policies.

Patient Signature: _____

Signature of Patient/Legal Guardian: _____

Date: _____

OralID™

ORAL CANCER SCREENING CONSENT FORM

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID™ examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

One American dies every hour from oral cancer. Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, the chances of survival are dramatically reduced.

We are concerned about oral cancer and look for it in every patient. We recommend all of our patients be screened with the OralID™to reduce both the incidence and mortality rates of oral cancer. *More than 25% of oral cancer victims have no such lifestyle risk factors.*

Who is at Risk?

- Patients ages 17+
- Tobacco Use
- Alcohol Use
- HPV infection

The OralID™ exam will be offered to you annually. This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D043 1; however, this exam might not be covered by your insurance. The fee for this enhanced examination is **$25.**

Patient Name: _____

Patient Signature: _____

Signature of Parent/Legal Guardian: _____

Date: _____