Celina Longoria, D.D.S

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Driver's License #: _____ **Email**: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____

Reason for today's visit: _____

Have you ever had any complications following dental treatment? Please circle: YES or NO

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Please circle: YES or NO

If yes, please explain: _____

Are you now under the care of a physician? YES or NO Name of Physician: _____

If yes, please explain: _____

Are you taking any medications? YES or NO

Over the counter?

_____

Prescription medications?

_____

Do you require PRE-MED?

_____

Referral Information

Whom may we thank for referring you to our practice? Please circle:

Current Patient Relative Work School Internet

Advertisement Other Name: _____

Indicate which of the following condition do you have or had.

Please check all that apply:

☐ ADD	☐ ADHD	☐ Acid Reflux Disease	☐ Adhesive Allergy
☐ Alzheimer's	☐ Anemia	☐ Aneurism	☐ Anxiety
☐ Arthritis	☐ Artificial Joints	☐ Aspirin/Blood Thinner	☐ Asthma
☐ Autism	☐ Bi-Polar	☐ Blood Disease	☐ C-Diff
☐ Cancer	☐ Cerebral Palsy	☐ Chest Pain/ Angina	☐ Celiac Disease
☐ Codeine Allergy	☐ Dementia	☐ Depression	☐ Diabetes
☐ Dizziness	☐ Epi Allergy	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting	☐ Fibromyalgia	☐ Food Allergy	☐ GERD
☐ Glaucoma	☐ Gluten Allergy	☐ Gout	☐ Growths/Tumors
☐ HIV	☐ Hashimoto Disease	☐ Head Injuries	☐ Heart Disease
☐ Heart Murmur	☐ Heart Palpitations	☐ Hepatitis	☐ High Cholesterol
☐ High Blood Pressure	☐ Hip Surgery	☐ Jaundice	☐ Kidney Disease
☐ Latex Allergy	☐ Liver Disease	☐ Low Blood Pressure	☐ Mastectomy
☐ Mental Disorders	☐ Metal/Nickel Allergy	☐ Migraines	☐ Mitro valve Prolapse
☐ Morphine	☐ Multiple Sclerosis	☐ Nervous Disorder	☐ NSAID's
☐ Pacemaker	☐ Pancreatitis	☐ Parkinson's	☐ Penicillin Allergy
☐ Pre-Med	☐ Prednisone	☐ Pregnant	☐ Radiation Treatment
☐ Replacement Joint	☐ Respiratory problems	☐ Rhematic Fever	☐ Rheumatism
☐ SVT- Ablation	☐ Scoliosis	☐ Seasonal Allergy	☐ Seizures
☐ Sickle Cell Carrier	☐ Sinus Problems	☐ Sjorgen's Syndrom	☐ Spleen Removal
☐ Stent	☐ Stomach Problems	☐ Stroke	☐ Sulfa Allergy
☐ Tetracycline	☐ Thyroid Problems	☐ Titanium Allergy	☐ Tricor
☐ Tuberculosis	☐ Tumors	☐ Ulcerative Colitis	☐ Valve Replacement
☐ Venereal Disease	☐ Vertigo	☐ Other	

Are you Pregnant(females):_____ Are you on Birth Control: _____

Medication Allergy: _____

Pharmacy Name & phone number: _____

If any conditions selected above need further clarification, please describe:

_____

Signature of patient, parent, or guardian: _____

Celina Longoria, D.D.S

Spouse or Responsible Party Information

The following is for ☐ Spouse ☐ Person Responsible for Payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other: _____

Social Security #: _____ Date of Birth: _____

Phone # (Home) _____ (work)_____ (Cell) _____

Address: _____

Street City State Zip Code Apartment #

Employment Information

Employer: Name: _____ Occupation: _____

Address: _____

Street City State Zip Code Phone

Dental Insurance Information

Primary Holder Name: _____ Is the Insured a Patient? Yes No

Last First MI

Primary Holder Date of Birth: _____ ID#: _____ Group#: _____

Insured's Address: _____

Street City State Zip

Insured Employer Name: _____

Address: _____

Street City State Zip Code

Relationship to Insured Self Spouse Child Other: _____

Insurance Plan Address: _____

Secondary (If Applicable) _____ Name of Insured: _____

Last First MI

Insured Date of Birth: _____ ID#: _____ Group#: _____

Insured Address: _____

Street City State Zip Code

Insured Employer Name: _____

Employer Address: _____

Street City State Zip Code

Relationship to Insured: Self Spouse Child Other: _____

Insurance Plan Address: _____

Street City State Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement form the patients for the costs incurred in their case 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 finance arrangement, 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.

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 fixe (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 here under 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:

Signature:

X_____Date:_____

Relationship to Patient: _____

Signature of guarantor of payment/responsible party:

X_____Date:_____

Relationship to Patient: _____

Celina Longoria, D.D.S

We are pleased you have chosen Celina Longoria D.D.S. for your dental needs. In order to better inform you, please read the following summary of our financial policy.

Insurance

You, as the patient, are responsible for all charges regardless of insurance coverage. As a courtesy to our patients, we will file your dental insurance for you. We will, to the best of our ability, provide the insurance company with all the necessary radiographs and narratives to get your insurance claim paid. There are times, however, when a dental claim goes to the dental review board for consideration. It is within the review board's discretion to accept or deny the claim. If the claim is denied, then the patient is responsible for payment. You as the insured have the right to appeal, but at that point when we have exhausted all our means, we cannot get involved and the balance must be paid in full by the patient.

Payments

As a courtesy to our patient, we accept MasterCard, Visa and checks with proper identification. There will be a $25.00 charge on all returned checks, and the balance must then be paid in full whether it is cash or money order. If the balance remains unpaid, we will not see the patient until the balance has been cleared. Patients with an outstanding balance of 30 days or more overdue must make arrangements for payments prior to scheduling appointments.

If treatment needs to be performed and your total cost has been explained to you, we do expect payment at the time treatment is rendered. By your cost, we mean your percentage of the "estimated" cost for treatment per your insurance company (co-insurance, deductible, and/or co-payment). We are a provider for many insurance companies; therefore, we accept the fee in which they allow us to charge; please keep in mind that when we call for verification of benefits, nothing is guaranteed. It is only an estimate until the insurance companies review the claim.

Missed Appointment/Late/Cancellations

Your appointment is time set aside for you. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time reserved for you. Please call our office and speak to an appointment coordinator 24 hours prior to your appointment if you must cancel or reschedule. Unfortunately, if the required notice is not given, a fee of $40.00 will be charged if scheduled with our hygienists and/or a $75 charge with scheduled restorative work with Dr. Longoria. This must be paid before the next visit. Excessive abuse of this policy may result in discharge from the practice. We do realize that emergencies do occur and will take this into consideration on a patient-to- patient basis.

I have read and understand the Celina Longoria D.D.S. financial policy. I agree to assign insurance benefits to Celina Longoria D.D.S. when necessary. I also agree that should it become necessary to forward my account for collection proceedings, in addition to the amount owed, I will also be responsible for the fees associated with the costs of collection.

_____ Signature

_____ Witness

_____ Date

_____ Printed Name of Witness

_____ Relationship if signed by Patient's Representative

Celina Longoria, D.D.S

HIPPA PRIVACY
ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I,_____(Please print out full legal name here) (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy (the "Policy") of Celina Longoria D.D.S., and have been offered a copy of such policy to keep for my records.

_____(Please initial here) hereby acknowledge that I have read the Policy and understand its terms and conditions.

_____(Please initial here) hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgment, Dr. Celina M. Longoria or other Provider may still provide treatment to me.

_____ _____
Patient Signature Date

For Office Use Only

I,_____, (please print full legal name here), acting as Receptionist/Office Manager for Dr. Celina M. Longoria attempted to obtain the written acknowledgment of Receipt of the HIPP A Policy of Provider on (date) _____

(Please insert date attempt was made), but acknowledgment could not be obtained

because:

____(Please initial here) Patient or Patient's legal representative refused to sign.___(Please initial here) Patient or Patient's legal representative could not be communicated with sufficiently to obtain acknowledgment.

_____ (Please initial here) Emergency circumstances prevented securing

acknowledgment.

____(Please initial here) Other (Please specify) _____

_____ _____
Signature of Provider Representative Date

Celina Longoria, D.D.S

TRAVEL ALERT

Have you traveled outside the country within the past 30 days? YES or NO

If you have traveled outside the country, where? _____

Have you been in contact with anyone who has traveled outside the country with the past 30 days? YES or NO

Have you experienced any FLU-like symptoms in the last 72 hours? YES or NO

- Muscle Pain
- Severe Headache
- Weakness
- Fever
- Nausea
- Vomiting
- Diarrhea
- Abdominal Pain
- Unexplained bleeding/bruising

Has anyone you have come in contact with had any FLU-like Symptoms as listed above? YES or NO

Patient Name _____

Patient Signature _____

Date of Visit _____