

# 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 #: \_\_\_\_\_ Preferred appointment times:  Morning  Afternoon  Evening

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for today's visit: \_\_\_\_\_  
Have you ever taken any of the following? Please check those that apply:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Pregnancy            | <b><u>ALLERGIES:</u></b>                                 |
| <input type="checkbox"/> Allergies _____    | <input type="checkbox"/> Growths             | Due Date: _____                               | <input type="checkbox"/> Aspirin                         |
| <input type="checkbox"/> Allergies _____    | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Codeine                         |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Penicillin                      |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Acrylic or Latex                |
| <input type="checkbox"/> Arthritis Joints   | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> Metal                           |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> Other                           |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems     |  |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Stroke               |  |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Tuberculosis         | <b><u>PREMEDICATE</u></b>                                |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Mental Disorders    | <input type="checkbox"/> Tumors               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nervous Disorders   | <input type="checkbox"/> Ulcers               |  |
| <input type="checkbox"/> Fainting           | <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Venereal Disease     |  |

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No Name of Physician: \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_ Phone: \_\_\_\_\_
- Are you taking any medications?  Yes  No Over the counter? \_\_\_\_\_ Prescription? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

\_\_\_\_\_  
Signature of patient, parent, or guardian Date: \_\_\_\_\_

## Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Internet  Insurance Company  Advertisement  School  Work  Other  
Name of person or advertisement referring you to our practice: \_\_\_\_\_

# Celina Longoria, D.D.S

## Spouse or Responsible Party Information

The following is for  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Ext): \_\_\_\_\_ (Cell): \_\_\_\_\_

Address: \_\_\_\_\_  
 Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## Employment Information

The following is for  the patient's spouse  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
 Street \_\_\_\_\_ City, \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

## Insurance Information

**Primary**

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
 Last First MI

Insured's Birth Date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
 Street \_\_\_\_\_ City, \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 Street \_\_\_\_\_ City, \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan and Address: \_\_\_\_\_

**Secondary**

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
 Last First MI

Insured's Birth Date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
 Street \_\_\_\_\_ City, \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 Street \_\_\_\_\_ City, \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan and Address: \_\_\_\_\_

## 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 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.

A service charge of 1 1/2% per month (18% per annum) on unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six 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 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:

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

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

# 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 and immediately payable. 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 HIPPA Policy of Provider on

\_\_\_\_\_  
(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 \_\_\_\_\_