UPTOWN
COSMETIC & IMPLANT DENTISTRY

Patient Information *(CONFIDENTIAL)*

Name _____ Preferred Name _____

Title _____ Birth Date _____ Social Security # _____

Gender: □ Male □ Female **Family Status** □ Married □ Single □ Child
Home Ph _____ Mobile Ph _____ Work Ph _____

Address _____APT#____ City _____State _____ Zip Code ___

E-mail: _____ Employer _____

Which is the best form of contact? □ Home □ Work □ Mobile □ Text Message □ Email

Whom may we thank for referring you to our practice? □ Patient /Doctor If so who_____

□ Google □ Website □ Insurance □ Facebook □ T.V Ad If so which one, _____

Primary Dental Insurance Information Relationship to insured: □ Self □ Spouse □ Child

Name of Insured _____Insured's Birth Date _____

Subscriber ID # _____Group # _____Employer Name _____

Insurance Carrier Name _____ Insurance Phone _____

Pharmacy Contact Information

Pharmacy Name:_____ Pharmacy Phone Number:_____

Pharmacy location:_____

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. In all cases requiring lab work such as crowns, dentures or bridges we request a minimum down payment of 50%.

If choose to be contacted via text or email I authorize Uptown Cosmetic & Implant Dentistry to send electronic appointment reminders to me. I understand text charges from my cell phone provider may apply. I understand that email may not be the safest form of communication as they can be intercepted during transmission

I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health care practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that if my insurance carrier has not paid for services rendered by 90 days I will have to pay any balance on my or my dependents account. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

_____ _____

Signature of Patient (or parent if minor) Date

PATIENT HEALTH HISTORY

Physician _____Physician Ph _____ Date of Last Exam_____

1. Are you under medical treatment? □ Yes □ No
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 yrs? □ yes □ No If yes, please explain _____ _____
3. Are you taking any medication(s) including non-prescription medications? □ Yes □ No
Please list _____ _____ _____ _____
4. Do you use tobacco? □ Yes □ No
5. Are you allergic to or have had any reactions to the following (check all that apply)
□ Local Anesthetics (e.g. Novocaine)
□ Penicillin or any other antibiotic
□ Sulfa Drugs
□ Barbiturates
□ Iodine
□ Aspirin
□ Any metals (e.g. nickel, mercury, etc)
□ Latex Rubber
□ Other _____
6. Women only: Are you pregnant or think you may be pregnant? □ Yes □ No
*For those patients using oral contraceptives: Please be advised that the use of certain antibiotics can reduce the effectiveness of Birth Control. If you have any concerns, please speak with the doctor.
7. Do you have or have you had any of the following? (check all that apply) Please note: If you do not check a box it will be assumed you do not have the condition.

□ High Blood Pressure
□ Swollen Ankles
□ Low Blood Pressure
□ Diabetes
□ Thyroid Problem
□ Heart Murmur
□ Cancer
□ Hepatitis/ Jaundice
□ Chest Pains
□ Hay Fever/Allergies
□ Glaucoma
□ Heart Trouble
□ Heart Attack
□ Fainting/Seizures
□ Epilepsy/Convulsions
□ Kidney Disease
□ Heart Disease
□ Angina
□ Arthritis
□ Sexually Transmitted Disease
□ Easily Winded
□ Tuberculosis
□ Recent Weight Loss
□ Respiratory Problems
□ Rheumatic Fever
□ Asthma
□ Leukemia
□ AIDS or HIV Infection
□ Cardiac Pacemaker
□ Emphysema
□ Joint Replacement or Implant
□ Stroke
□ Radiation Therapy
□ Liver Disease
□ Mitral Valve Prolapse

PATIENT DENTAL HISTORY

Reason for Today's Visit_____ Last Dental Visit_____
For what reason was your previous dental visit _____ Previous Dentist _____
1. Do you experience any of the following? (Check all that apply)

□ Bleeding gums
□ Teeth sensitivity to sweet or sour liquids/foods
□ Teeth sensitivity to hot or cold liquids/foods
□ Pain in any of your teeth
□ Sores or lumps in or near mouth
□ Frequent headaches
□ Clench or grind teeth
□ Bite lips or cheeks frequently

2. Have you had any head, neck or jaw injuries? □ Yes □ No
3. Have you experienced any of the following problems in your jaw? (check all that apply)

□ Clicking
□ Difficulty in chewing
□ Pain (joint, ear, side or face)
□ Difficulty in opening or closing

4. Have you ever had prolonged bleeding following extractions? □ Yes □ No
5. Have you had any orthodontic treatment? □ Yes □ No
6. Do you wear dentures or partials? □ Yes □ No If yes, date of placement _____
7. Have you ever received oral hygiene instructions? □ Yes □ No
8. Do you like your smile? □ Yes □ No
9. If by magic you could change anything about your teeth, what would you change? _____
Additional Comments: _____

_____ _____
Signature of Patient (or parent if minor) Date

I, _____, have read a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (Please specify)

_____

_____

_____

Appointment No Show/Cancellation Policy

As a dental specialty dental practice, our day is carefully scheduled with every effort given to proper time allotments for individualized care of each of our patients. Preparation procedures including supplies, equipment and staffing can be extensive and costly. When an appointment is scheduled, that time has been set aside for you and when it is missed or rescheduled with late notice, that time cannot be used to treat another patient. We have therefore implemented the following policies regarding no shows and cancelled appointments.

Our policy is as follows

- We require that you give our office 48 hours (business hours) notice in the event that you need to reschedule your appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility.
- Surgery appointments that are cancelled without 72 hour (business hours) notification will be charged $100 per hour. Our office will inform you regarding these cases.
- No future appointments can be scheduled nor can records be transferred without the payment of this fee.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient **Date**

Thank you for your understanding and adherence to this policy.

AUTHORIZATION FOR USE OF PICTURES IN ANY FORMAT

I authorize the use of my pictures in any format to Dr. Roberto Velasco, D.D.S. and Uptown Cosmetic & Implant Dentistry.

_____ _____

Signature Date

AUTHORIZATION FOR USE OF PICTURES IN DENTAL PUBLICATIONS

I authorize the use of my pictures in any format to Dr. Roberto Velasco, D.D.S. and Uptown Cosmetic & Implant Dentistry.

_____ _____

Signature Date

AUTHORIZATION FOR USE OF PICTURES IN OFFICE

I authorize the use of my pictures in any format to Dr. Roberto Velasco, D.D.S. and Uptown Cosmetic & Implant Dentistry.

_____ _____

Signature Date

PATIENT ADVISEMENT

CT-SCAN (CBCT) WAIVER OR ACCEPTANCE FORM

Our Doctors will interpret your CT-Scan image solely for the purpose of evaluating your upper and lower jaw for treatment planning and placement of Dental Implants. It has not been read for the presence of any medical condition. You may want to have this film interpreted by a physician (radiologist) of your choosing and at your expense for the presence of any medical condition(s). Should you desire, **UPTOWN Cosmetic and Implant Dentistry** will provide you with a copy of your CT-scan for a fee of $250.00. We can refer you to a maxillofacial radiologist should you need a referral for this purpose. Please sign this form indicating your decision.

I have elected to have a Ct-Scan (CBCT) taken, and I

Want ☐

Do Not Want ☐

To take a copy home with me today.

Patient Signature _____ Date _____

Print Name _____