Welcome!

Thank you for choosing our office. We are honored for the opportunity to provide gentle, quality dental care. If you have any questions or we can help you in any way, please feel free to ask our doctors or staff.

Dr. Bruce D. Waterman D.M.D., P.A. Dr. Andrea D. Gordillo D.M.D., PA

Patient Information (Confidential):

Name ______________________________________ (If child, parent/guardian name) __________________________
Last name *First name* *Last name* *First name*

Birthdate ___________________ Sex _________ Age _______ Soc Sec # _______________Marital Status_______
Home Address ____________________________________ City __________________ State ______ Zip __________
Home Phone ________________ Work Phone _______________ Cell Phone ________________
Email _______________________________ Would you like us to confirm your appointment with email? ___________

Employer _____________________ Occupation _________________How long there? ______ May we call? _________
Employer Address _____________________________________ City ________________ State _____ Zip __________

Spouse's Name (Or parent/guardian) _______________________ Soc Sec # _______________ Birthdate ___________
Spouse's Employer __________________ Occupation ______________How long there? ______ May we call? _______
Employer Address _____________________________________ City ________________ State _____ Zip __________

If patient is a student: Name of School/College: ____

In case of emergency:

Nearest Relative Not Living With You: _______________________ Relationship ___________ Phone _______________
Address ____

Nearest Friend Not Living With You: _______________________ __________ Phone _______________________
Address ____

How did you hear about our practice? ____

Primary Insurance (Dental):	Additional Insurance (Dental):
Name of Insured: ________________________________	Name of Insured: ________________________________
Birthdate: ______________	Birthdate: ______________
Relationship to patient _______________	Relationship to patient ________________
Employer ______________________________________	Employer ______________________________________
Address (if different than patient) ______________________	Address (if different than patient) ______________________
Social Security # ___________ Subscriber ID _____________	Social Security # ___________ Subscriber ID _____________
Group, Contract , Local or Union # _____________________	Group, Contract , Local or Union # _____________________

Name and City of primary care physician ____
Someone we may contact, not living with you: _________________________ Phone # ___________________________

Authorization:

Please present this form, your driver's license and all insurance ID cards to the receptionist at this time. Please read the following authorization and sign the form where indicated.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collections costs if this office determines they are necessary. Our office can only ***estimate*** insurance benefits, and therefore can not guarantee your portion. I authorize my insurance company to make payments directly to Dr. Waterman/Dr. Gordillo for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I have read and understand the above and agree to comply.

X ____ ____________________________
Patient Signature Date

Dental History (Confidential):

Patient Name ____ Age _______ Date _________________
Reason for seeking care today : Exam _____ Cleaning _____ Specific Problem __________________________________
(Please Describe)
Date of last visit to the dentist _________________________ Reason for your last visit ___________________________
Do you have x-rays or dental records ___________________

Please check all that apply:

- ☐ Toothache
- ☐ Broken filling or tooth
- Sensitivity to:
  - ☐ Cold
  - ☐ Hot
  - ☐ Sweets
  - ☐ Chewing
- ☐ Food catches
- ☐ Loose teeth
- ☐ Floss breaks easily or hurts
- ☐ Bite or teeth have shifted
- ☐ Often bite cheeks
- ☐ Frequent dry mouth
- ☐ Concerned about breath
- ☐ Unhappy with previous dental work
- ☐ Gums bleed
- ☐ Gums tender
- ☐ Growths, sores
- ☐ Cold sores, fever blisters
- ☐ Cracked, chapped lips
- ☐ Bad taste in mouth
- ☐ Sinus problems
- ☐ Mouth breathe-Difficulty breathing through nose
- ☐ Dry or strained eyes
- ☐ Shoulder, neck or headaches
- ☐ Clench or grind teeth
- ☐ Jaw joint pain
- ☐ Clicking or popping of joint
- ☐ Unable to open mouth wide
- ☐ Jaw gets tired easily
- ☐ Hold things between teeth (Pipe, pencil, nails, pins)
- ☐ Bite fingernails
- ☐ Unusual habits with teeth
- ☐ Wore braces
- ☐ Previous gum treatment
- ☐ Previous bite treatment

Have you ever fainted? _________________________ Had an allergic reaction to anesthetics? ___________________
Would you like whiter teeth? _______ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile? ____
Please rate 1-10 how anxious you are about dental treatment (1= totally relaxed) ____________
Why did you leave your previous dentist? ___________________________
Did your parents have difficulties with their teeth or dental treatments? ________________________

Medical History (Confidential):

Physicians Name: _____________________________
City ______________________ Phone __________
Have you been hospitalized for any reason? _______
Please Describe: ______________________________
____
Are you taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed) ______________________________
____
____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other? ____
Do you smoke? How much/day? _______________________________
Pregnant? Due Date __________ Are you nursing? ______________
Are you seeing a physician now or planning to see one for any reason?
Please explain: ____
____
____
____
____

Write YES for all that apply:

Heart Attack ______
Angina ______
Heart Murmur ________
Rheumatic Fever ______
Mitral Valve Prolapse ______
Irregular Heartbeat ______
High/Low Blood Pressure ______
Pacemaker ______
Artificial Heart Valve ______
Congenital Heart Disease ______
Diabetes ______
Osteoporosis Drugs ______
HIV or AIDS ______
Kidney Problem ______
Liver Problem _______
Cancer ______
Respiratory Problem ______
Asthma ______
Blood Disorder ______
Digestive Problem ______
Glaucoma ______
Stroke ______
Nervous Disorder ______
Snoring/Sleep Apnea _______
Back Problem ______
Fainting or Dizzy ______
Drug/Alcohol Addiction ______
Hepatitis _____

Any other illnesses not listed above: ____
____
____
____
____
____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: ☐ Yes ☐ No

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent/guardian) **X** ____ Date _________________________
Dentist Signature ____ Date ___________________________

Dental Laser Center Office Guidelines

We greatly appreciate that you have selected our office to care for your dental needs. We value our patients and strive to provide the highest quality care. In so doing, we would like to take a moment to share some of our office guidelines with you. Please review the following and feel free to speak to anyone on our staff if you have questions or concerns.

Appointment Guidelines:

The majority of our patients honor their obligation by keeping their dental appointments. These appointments are time reserved exclusively for you.

1) APPOINTMENT CONFIRMATION COURTESY: As a courtesy, we try to call all our patients to confirm their appointments. In this day and age of voicemail and active schedules, we frequently have to leave a message. Regardless, it is the responsibility of the patient who made the appointment to know when their appointment is scheduled and to fulfill this commitment. It is an unacceptable excuse that an appointment was not kept because we could not personally remind an individual. Any need to change the appointment should be at least 24 hours in advance. We understand there can be emergencies and special circumstances that are the exception.

2) BROKEN APPOINTMENTS: Appointments that are not honored or that are cancelled with less than 24 hours notice are considered broken appointments. After one broken appointment, any future broken appointments will have a fee assessment. Habitual and repeated broken appointments may result in our requesting that records be transferred to another dentist.

3) APPOINTMENT TARDINESS: Over 15 minutes late for an appointment may require us to reschedule the appointment or modify procedures for that day. Habitual tardiness creates hardship for our office and other patients as it puts us behind the rest of the day. If this becomes a regular problem, limited appointment availability and fee adjustments may be necessary.

Insurance Guidelines

1) COURTESY FILING OF INSURANCE: We will file your insurance as a courtesy, collect the estimated patient share and coordinate any balance billing.

2) INSURANCE BENEFITS: Insurance policies continuously change and therefore coverages are not totally predictable. Policies may have UCR's and/or substitute less expensive procedures in their fine print. When we calculate your share it is only an estimate. We do our best, but cannot always predict what the insurance will cover. For more information on Dental Insurance please ask our front desk staff for a brochure on insurance coverage and benefits.

3) NETWORK DENTAL PLANS: Our office is an *Out of Network* provider for **ALL** insurance plans. We see many patients as an out of network provider. On occasion our fees may be higher than Network Provider fee allowances. Since there are thousands of these network plans and their benefits change often, we again can only estimate your share after insurance.

I have read and understand the office guidelines of the Dental Laser Center.

________________________________ ____________

Signature Date

HIPPA PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment:;
- Obtaining payment from third party payers (e.g. my insurance company);
- The day to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the term of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

As of May 1st 2009, new federal guidelines require photo ID at your initial visit.

Signed this _____ day of _______, 20 ____.

Print Patient Name: ___________________________

Relationship to Patient: ________________________

Signature: __________________________________

Dental Laser Center, LC
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