

Patient History Update

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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? _____

Primary Insurance (Dental):

Name of Insured: _____
Birthdate: _____ Relationship to patient _____
Address (if different than patient) _____
Insurance Company: _____
Social Security # _____ Subscriber ID _____
Group, Contract, Local or Union # _____
Employer: _____

Additional Insurance (Dental):

Name of Insured: _____
Birthdate: _____ Relationship to patient _____
Address (if different than patient) _____
Insurance Company: _____
Social Security # _____ Subscriber ID _____
Group, Contract, Local or Union # _____
Employer: _____

Authorization:

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

Medical History (Confidential):

Physicians Name: _____
City _____ Phone _____
Have you been hospitalized for any reason? _____
Please Describe: _____
Are you seeing a physician now or planning to see one for any reason? Please explain: _____

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 taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed)

Write YES for all that apply:

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

Any other illnesses not listed above: _____

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.

X _____
Patient Signature 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 coverage's 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