Eldorado Dental

1701 W. Eldorado Pkwy Suite 210
McKinney, Texas 75069
469. 952 .2712

Name:_____

DENTAL HISTORY

Please check any of the following that apply to you.

-Sensitivity (hot, cold, sweet) ☐
Where? UR LR UL LL

-Headaches, earaches, neck pain ☐
-Jaw joint pain ☐
-Teeth or fillings breaking ☐
-Grinding or clenching teeth ☐
-Bleeding, swollen or irritated gums ☐
-Loose, tipped or shifting teeth ☐
-Bad breath ☐

Do you have or have you had any of the following?

-Dentures ☐
-Partial dentures ☐
-Braces ☐
-Gum treatments ☐

Please share the following dates:

-Your last cleaning ___ / ___
-Your last oral cancer screening ___ / ___
-Your last complete X-Rays ___ / ___

Name of Previous Dentist _____

City _____ **State** _____
Phone Number _____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐

Do you smoke or use chewing tobacco?
How much? For how long?

If I could change my smile, I would: ☐
-Make them whiter ☐
-Make them straighter ☐
-Close spaces ☐
-Replace black metal fillings with tooth colored restorations ☐
-Repair chipped teeth ☐
-Replace missing teeth ☐
-Replace old crowns that don't match ☐
-Have a smile makeover ☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____
_____

What is the most important thing to you about your dental visit today? _____
_____

What is the most important thing to you about your future smile and dental health? _____
_____

Eldorado Dental- Adult

PATIENT NAME: _____PREFERRED NAME: _____
O MALE 0 FEMALE 0 MARRIED 0 SINGLE 0 CHILD 0 OTHER _
HOME ADDRESS:_____CITY:_____ZIP:_____
PHONE (HOME):_____ (WORK): _____EXT _____(CELL):_____
SOCIAL SECURITY #:_____ BIRTH DATE:_____
DRIVER'S LICENSE # STATE _____
E-MAIL ADDRESS: _____
EMPLOYER NAME: _____

Please list other members of your immediate family who are patients in our office:
_____

Referral Information

Can we thank someone for referring you? _____
Or did you find us on your own and how?
Please circle source:
Family member or friend:_____ , insurance website, dental website, yellow pages,
other:_____
Date of Last Dental Visit: _____

We routinely use latex products for your safety. If you have a known sensitivity to latex products, please notify us prior to being called back to the treatment room.

Insurance Information

Name of Insured: _____
Insured's Birth Date:_____ SS# _____Group # _____
Patient's relationship to insured: 0 Self 0 Spouse 0 Child 0 Other _
Dental insurance company name: _____Phone #: _____

*Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

Signature of patient, parent, or guardian_____

Date: _____

Eldorado Dental

MEDICAL HISTORY

Patients Name: _____ **Birth Date**: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes please explain: _____
Have you ever been hospitalized or had a major operation? O Yes O No If yes please explain: _____
Have you ever had a serious head or neck injury? O Yes O No If yes please explain: _____
Are you taking any medications, pills, or drugs? O Yes O No If yes please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? O Yes O No _____
Are you on a special diet? O Yes O No _____
Do you use tobacco? O Yes O No
Do you use controlled substances? O Yes O No

Women: Are you
Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics
O Other: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Renal Dialysis	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Rheumatic Fever	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Rheumatism	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Scarlet Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Shingles	O Yes O No
Arthritis/Grout	O Yes O No	Epilepsy/Seizures	O Yes O No	Hives/Rash	O Yes O No	Sickle Cell Disease	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hypoglycemia	O Yes O No	Sinus Trouble	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Irregular Heartbeat	O Yes O No	Spina Bifida	O Yes O No
Asthma	O Yes O No	Fainting spells/Dizzy	O Yes O No	Kidney Problems	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Leukemia	O Yes O No	Stroke	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Liver Disease	O Yes O No	Swelling Of Limbs	O Yes O No
Breathing Problem	O Yes O No	Frequent Headaches	O Yes O No	Low Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Lung Disease	O Yes O No	Tonsillitis	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tuberculosis	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Cold Sore/Fever Blister	O Yes O No	Heart Murmur	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pace Maker	O Yes O No	Radiation Treatments	O Yes O No	Yellow Jaundice	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Recent Weight Loss	O Yes O No		

Comments: _____
_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ DATE: _____

Dr. Antonio Reyes, D.D.S.
1701 W. Eldorado Pkwy Ste. #210
McKinney, TX 75069
Phone: 469-952-2712
Fax: 469-952-2714

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I, _____, understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment as well as follow up among the multiple healthcare providers (if applicable) who may be involved in my treatment directly and indirectly.
- Obtain payment from insurance companies and/or third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given a copy of your Notice of Privacy Practices with my paperwork containing a more complete description of the uses and disclosures of my health information. I have been given the time and opportunity to read your Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that Eldorado Dental has the right to change its Notice of Privacy Practices and that I may contact them at any time to obtain a current copy.

By signing you certify that you have received and read Eldorado Dental's Notice of Privacy Practices.

Signature: _____ Date: _____
If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Print Name_____

Source of Authority (parent/guardian/ect.)_____

*****In non "legal" language, this means we will only use your information to file your insurance, provide dental care to you, collect our fee and communicate with other health care providers that we have referred you to.*****

Cancellation and No Show Policy

To avoid last minute cancellations and no shows, please acknowledge Eldorado Dental's cancellation policy. **If you need to reschedule or cancel, we ask you to give us a 24 hour notice to avoid a fee of $50.00.** The Dr. sets aside a certain amount of time just for your visit, and to give you his personal attention. No shows and last minute cancellations cause lost time on his part that he could be using to help another patient. **Please give us the courtesy of 24 hours to reschedule or cancel to avoid charges.**

Thank you,

Eldorado Dental
Kim Reyes
Office Manager

I have read the above and agree:
Signature of patient, parent, or guardian: _____
Date: _____
Relationship to Patient: _____

ELDORADO DENTAL

INFORMATION SHARING CONSENT FORM

NAME: _____

My preferred method of communication regarding my dental conditions is indicated below (**check all that apply**):

- o **Home Phone**
- o **Work Phone**
- o **Email**
- o **Cell Phone/Text**
- o **Mailed Letter**
- o **Parent/Guardian**

If the above method of communication is by phone, please check the appropriate box below (**check one**):

- o **Leave a message with detailed information such as appointment date or time, procedure to be preformed, ect.**
- o **Leave a message with our call back number only.**

Keeping our patients information private is important to us and we will only discuss information related to the patients account (such as balance or cost of treatment), dental conditions and medical conditions with the patient or parent/legal guardian if the patient is under the age of 18.

If you would like to add additional contacts (other than yourself or parent/legal guardian) that Eldorado Dental is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each contact you list. In addition, please choose the contact you would like Eldorado Dental to use as your emergency contact in the event of an emergency.

_____	_____	_____
Contact Name	Relationship to Patient	Contact Phone Number

O Account Information **O Dental Treatment** **O Medical Conditions** **O Emergency Contact**

_____	_____	_____
Contact Name	Relationship to Patient	Contact Phone Number

O Account Information **O Dental Treatment** **O Medical Conditions** **O Emergency Contact**

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or your insurance company. Some insurance companies require this in order to make a payment on services rendered and this allows any specialist we may refer you to to have a better diagnostic tool available to them and provide you with quicker service. Please check below acknowledging you consent to this action if ever necessary.

- o **I give my permission for this action**
- o **I do not give my permission for this action**

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed in this form will require my specific authorization prior to the disclosure of any information.

I, _____, have had the full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent on your use and disclosure of my protected health information to carry out treatment, payment activities, and appointment information.

Signature: _____ Date: _____