

Eldorado Dental- Child

Patient Information

Patient Name: _____ Preferred Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____

Address: _____ City: _____ Zip: _____

Parent/Guardian Name: _____ Parent Phone# _____

Can we thank anyone for referring you? _____

Insurance Information

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ SS# _____

Group # _____

Patient's relationship to insured: Self Spouse Child Other _____

Dental insurance company name: _____

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

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

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

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

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

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

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

- Leave a message with detailed information such as appointment date or time, procedure to be preformed, ect.**
- 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
<input type="radio"/> Account Information	<input type="radio"/> Dental Treatment	<input type="radio"/> Emergency Contact
<input type="radio"/> Medical Conditions		

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<input type="radio"/> Account Information	<input type="radio"/> Dental Treatment	<input type="radio"/> Emergency Contact
<input type="radio"/> Medical Conditions		

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.

- I give my permission for this action**
- 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: _____