

Fidel Abreu DDS, PLLC

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's name _____ Preferred name _____

DOB ____/____/____

If minor, parent's names _____ Home phone#: _____ Cell phone#:

Home address _____ SSN: ____ - ____ - ____ City

State _____ Zip _____

Email _____ Emergency Contact _____ Phone#:

Employer _____ Occupation _____

Work#: _____

Reason for today's visit? Checkup and x-rays cleaning other

Whom may we thank for referring you to our office?

Insurance Information

Dental Insurance company: _____

Group#: _____

S.S #: ____ - ____ - ____ Member identification#: _____ dob ____/____/____

Person responsible for insurance: _____

Secondary Insurance

Secondary Insurance company: _____

Group#: _____

S.S #: ____ - ____ - ____ Member identification#: _____ dob ____/____/____

Person responsible for insurance: _____

Dental history

Date of last dental care: _____ last dental cleaning: _____ Last

Fmx _____

what was done in your last dental visit?

Check off, if you have had problems with of the following:

- | | | |
|----------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Smile sweets | <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Sensitivity to |
| <input type="checkbox"/> Bad Breath hot or cold | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to |
| <input type="checkbox"/> Bleeding Gums on biting or chewing | <input type="checkbox"/> Food collections between teeth | <input type="checkbox"/> Sensitivity |
| <input type="checkbox"/> Periodontal/Gums growth in your mouth | <input type="checkbox"/> Grinding Teeth (while awake or asleep) | <input type="checkbox"/> Sores or |

Notice of HIPPA A Privacy Policy

Patient/ Representative signature:

Medical Physician's Name: _____ Phone #: _____ Pharmacy #: _____

Are you currently under a physician's care? Yes No If yes, describe _____

Have you ever been hospitalized or had a major operation? Yes No
If yes, please describe _____

Do you take antibiotics prophylaxis before dental procedures? Yes No

Medical Health History

Do you have or have you had any of the following?
(Please check any that apply)

- | | | |
|---|---|---------------------------------------------------------|
| — | — | Cancer or tumor |
| — | — | Heart ailment or angina |
| — | — | Heart murmur, mitral valve prolapse, heart defect |
| — | — | Rheumatic fever or rheumatic heart disease |
| — | — | Artificial joint or valve |
| — | — | High or low blood pressure |
| — | — | Pacemaker |
| — | — | Tuberculosis or other lung problems |
| — | — | Kidney disease |
| — | — | Hepatitis or other liver disease |
| — | — | Alcoholism |
| — | — | Blood transfusion |
| — | — | Diabetes |
| — | — | Neurologic condition |
| — | — | Epilepsy, seizures, or fainting spells |
| — | — | Emotional condition |
| — | — | Arthritis |
| — | — | Herpes or cold sores |
| — | — | AIDS or HIV positive |
| — | — | Migraine headaches or frequent headaches |
| — | — | Anemia or blood disorders |
| — | — | Abnormal bleeding after extractions, surgery, or trauma |
| — | — | Hayfever or sinus trouble |

- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco? Yes no

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: _____

Women:

- May be pregnant
Expected delivery date: _____
- Taking hormones or contraceptives

Authorization

I understand the above information is necessary to provide me with dental care in safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider agency, which may release such information to you. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at my next appointment.

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for the services rendered. I authorize the use of my signature on all insurance submissions. **I am also aware and was explained that most insurance companies do not cover composite fillings. Therefore I would be responsible for a upgraded fee, if I choose to do composite.** I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by my insurance

***Signature of patient (or parent)** _____ **Date**

Payments is due in full at time of treatment unless prior arrangements have been made.

MISSED APPOINTMENT AND CANCELLATION POLICY-If you are unable to keep a schedule appointment, please give 24 hours advance notice, to ensure that you will not be charged for the appointment. If less than 24 hours notice is given and we are unable to fill your time slot, you will be charged for our broken apt fee of \$50.