

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PRIMARY PHYSICIAN INFORMATION**

Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_

**MEDICAL HISTORY**

GENERAL HEALTH:  EXCELLENT  GOOD  FAIR  POOR

- Y  N Under a physician's care now? \_\_\_\_\_
- Y  N Any hospitalization in the past 5 years? \_\_\_\_\_
- Y  N Any serious illnesses/surgeries? \_\_\_\_\_
- Y  N Use tobacco in any form? If Yes, Type: \_\_\_\_\_
- Y  N **Is pre-medication required before dental visits due to heart condition or artificial joint?**
- Y  N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS:  Y  N Currently nursing?  Y  N Currently pregnant? Due Date: \_\_\_\_\_

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients?  Y  N  
If yes, please describe: \_\_\_\_\_

Is there anything important about your medical condition we have not asked?  Y  N If yes, please describe: \_\_\_\_\_

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):  NONE

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> ACID REFLUX            | <input type="checkbox"/> BULIMIA                 | <input type="checkbox"/> HEARING PROBLEMS           | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> ADHD                   | <input type="checkbox"/> CANCER/MALIGNANCY       | <input type="checkbox"/> HEART ATTACK               | <input type="checkbox"/> RADIATION/CHEMO       |
| <input type="checkbox"/> AIDS/HIV               | <input type="checkbox"/> CEREBRAL PALSY          | <input type="checkbox"/> HEART DISEASE              | <input type="checkbox"/> RESPIRATORY DISEASE   |
| <input type="checkbox"/> ANEMIA                 | <input type="checkbox"/> CHEMICAL DEPENDENCY     | <input type="checkbox"/> HEART MURMUR               | <input type="checkbox"/> RHEUMATIC FEVER       |
| <input type="checkbox"/> ANOREXIA               | <input type="checkbox"/> CHICKEN POX             | <input type="checkbox"/> HEPATITIS                  | <input type="checkbox"/> SINUS PROBLEMS        |
| <input type="checkbox"/> ANXIETY                | <input type="checkbox"/> CONVULSIONS             | <input type="checkbox"/> HIGH BLOOD PRESSURE        | <input type="checkbox"/> STROKE                |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DEPRESSION              | <input type="checkbox"/> KIDNEY DISEASE             | <input type="checkbox"/> THYROID CONDITION     |
| <input type="checkbox"/> ARTIFICIAL JOINTS      | <input type="checkbox"/> DIABETES                | <input type="checkbox"/> LIVER PROBLEMS             | <input type="checkbox"/> TUBERCULOSIS          |
| <input type="checkbox"/> ARTHRITIS              | <input type="checkbox"/> DIZZINESS/FAINTING      | <input type="checkbox"/> MITRAL VALVE PROLAPSE      | <input type="checkbox"/> ULCERS                |
| <input type="checkbox"/> ASTHMA                 | <input type="checkbox"/> EPILEPSY/SEIZURES       | <input type="checkbox"/> MONONUCLEOSIS              | <input type="checkbox"/> VENEREAL DISEASE      |
| <input type="checkbox"/> AUTISM/ASPERGER'S      | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> PACEMAKER                  |  |
| <input type="checkbox"/> BLEEDING DISORDER      | <input type="checkbox"/> FREQUENT HEADACHES      | <input type="checkbox"/> OTHER – PLEASE LIST: _____ |  |

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):  NONE

- |   |                                  |   |   |                               |
|---|----------------------------------|---|---|-------------------------------|
| <input type="checkbox"/> ASPIRIN                    | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE    | <input type="checkbox"/> SLEEPING PILLS               | <input type="checkbox"/> NONE |
| <input type="checkbox"/> ANESTHETIC – LOCAL         | <input type="checkbox"/> DAIRY   | <input type="checkbox"/> METAL SENSITIVITY      | <input type="checkbox"/> SULFA DRUGS                  |                               |
| <input type="checkbox"/> BARBITURATES               | <input type="checkbox"/> LATEX   | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS |                               |
| <input type="checkbox"/> OTHER – PLEASE LIST: _____ |                                  |   |   |                               |

**MEDICATION INFORMATION**

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):  NONE

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS    | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY   | <input type="checkbox"/> DAILY ASPIRIN       | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS |
| <input type="checkbox"/> BLOOD THINNERS             | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS  | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN                    | <input type="checkbox"/> NITROGLYCERIN            | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS   |
| <input type="checkbox"/> OTHER DIABETIC MEDICATIONS | <input type="checkbox"/> RECREATIONAL DRUGS       | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS              |
| <input type="checkbox"/> OTHER (PLEASE LIST BELOW)  |   |  |   |

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>PATIENT NAME:</b>	<b>DATE:</b>
<b>DRUG NAME</b>	<b>REASON PRESCRIBED</b>

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HEALTH HISTORY UPDATE (Following Year/ Visit)**

Name: \_\_\_\_\_

Medical Alert: \_\_\_\_\_

Allergies: \_\_\_\_\_

Date: \_\_\_\_\_

Have there been any changes in your health history, new allergies? \_\_\_\_\_

Have there been any changes in medication?

\_\_\_\_\_

\_\_\_\_\_

Have you been hospitalized since your last appointment?  No  Yes, for what? \_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Staff Signature: \_\_\_\_\_

HEALTH HISTORY UPDATE

Name: \_\_\_\_\_

Medical Alert: \_\_\_\_\_

Allergies: \_\_\_\_\_

Date: \_\_\_\_\_

Have there been any changes in your health history, new allergies? \_\_\_\_\_

Have there been any changes in medication?

\_\_\_\_\_  
\_\_\_\_\_

Have you been hospitalized since your last appointment?  No  Yes, for what? \_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Staff Signature: \_\_\_\_\_

\_\_\_\_\_

HEALTH HISTORY UPDATE

Name: \_\_\_\_\_

Medical Alert: \_\_\_\_\_

Allergies: \_\_\_\_\_

Date: \_\_\_\_\_

Have there been any changes in your health history, new allergies? \_\_\_\_\_

Have there been any changes in medication?

\_\_\_\_\_  
\_\_\_\_\_

Have you been hospitalized since your last appointment?  No  Yes, for what? \_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Staff Signature: \_\_\_\_\_

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_

Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

**Patient Information**

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

**Section 2**

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

**Section 3**

Referred By: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

**Please take a moment to tell us about your smile so that we  
may better serve your individual needs**

When I see a picture of myself, the first thing I notice about myself is:

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Some things that I consider attractive in other people's smiles are:

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*Please (check mark) the statements that apply to you*

- I wish my teeth were straighter.*
- I wish I had a broader smile.*
- I think some of my teeth are too small.*
- I think some of my teeth are too large.*
- I wish my teeth were whiter with regard to their color.*
- I think my gums show too much when I smile.*
- I think my smile shows too much space between some of my teeth.*
- Because I am not totally pleased with my teeth, I sometimes hesitate to smile.*
- I feel as though I don't really know all of the options available to me for enhancing my smile.*
- Concerns over what the end results might look like have been a factor in my not having aesthetic dentistry in my mouth.*
- Concerns over fees have prevented me from taking advantage of the available options to enhance my smile.*
- I feel as though I could do a better job protecting the health of my teeth and gums, and therefore the longevity of my smile.*

**Jorge Alvarez DDS., P.C.**  
**6562 E. Carondelet Drive**  
**Tucson, AZ 85710**

Courtesy calls are made when possible; however it is the patient's responsibility to remember their dental appointments. Please check the bottom of your statement of services rendered to confirm all family appointments. If you call to make an appointment, please make sure to document the day and time it has been scheduled. **We do require a 2 working day advance notice to cancel an appointment in order to avoid being charged a \$50.00, per hour cancellation fee.**

**All fees are due at time of service.** Should this matter be turned over to collections, all cost including reasonable collection fees (40%) and court cost incurred by Dr. Jorge Alvarez, DDS, shall be borne by undersigned.

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**Patient/ Guardian Signature**

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**Date**

### **Dental Insurance Information**

**Thank you for choosing the office of Dr.Alvarez. We will be happy to help you file your dental insurance claims. We understand that dental insurance can be very confusing and will be happy to answer your questions to the best of our ability. Remember that we are here to serve you. Please help us by reading and acknowledging the following:**

- **Some insurance carriers limit the procedures they will cover. Please be assured that Dr.Alvarez will always recommend the treatment that is appropriate for your health, regardless of what an insurance company representative will approve.**
- **We will ESTIMATE your deductible and the amount covered on dental procedures. Please remember that this is only an estimate based on our history with your insurance company. If they should cover less than expected, you will be responsible for the balance. If they cover more, a credit will be applied to our account or a prompt refund will be mailed, depending on your preference.**
- **The insurance is a contract between you, your employer and the insurance carrier. We are not a party to that contract. We will make every effort to provide all the information to expedite the claim, but ultimately any uncovered procedure is the patient's responsibility.**
- **Please keep us informed if any treatment has been performed at another dental office so that we can more accurately estimate your remaining benefits.**
- **Please let us know if there have been any changes in your employment or insurance that might affect your benefits.**

**Thank you for reviewing our insurance policy. We want to avoid misunderstandings so that we may focus on your health.**

**I understand and accept Dr.Alvarez's policy on dental insurance.**

**Patient signature: \_\_\_\_\_**

**Date: \_\_\_\_\_**

**Jorge Alvarez DDS., P.C.**  
**6562 E. Carondelet Drive**  
**Tucson, AZ 85710**

**HIPPA consent to use protected health information for treatment, payment and health care operations.**

**I consent to allow Dr. Jorge Alvarez DDS., P.C. to use or disclose my protected health information for treatment, payment and health care operations.**

**Treatment means the provision, coordination, or management of health care and related services by one or more health care providers. Payment means the activities undertaken by a health care provider or health plan to obtain or provide insurance reimbursement for the provision of health care.**

**Health care operations mean conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Jorge Alvarez DDS., P.C.**

**I consent to allow Jorge Alvarez DDS., P.C. to disclose protected health care information to another provider for health care operations activities, provided that the other health care provider has or had a relationship with the below named patient. The disclosure must be for the treatment or other health care operations or for the purpose of health care fraud and abuse detection or compliance. I understand that the information in my dental record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services.**

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**Patient/Guardian Signature**

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**Date**