



PATIENT REGISTRATION

Patient Name: _____ **Last Name:** _____ **Middle Initial:** _____

Preferred Name: _____

Referred By: _____

Patient is: Responsible Party Policy Holder

Patient Information:

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

Birth date: _____ Social Security #: _____ - _____ - _____ Drivers License #: _____

E-mail: _____ I would like to receive email correspondences

Emergency Contact Name: _____ Contact #: _____

Employment Status: Full Time Part Time Self Employed Retired Unemployed

Employer Name: _____ Employer Address: _____

Student Status: Full Time Part Time

Preferred Dentist: _____ Preferred Hygienist: _____ Preferred Pharmacy: _____

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #: _____ - _____ - _____ Drivers License #: _____

Responsible Party is Policy Holder for Patient Primary Policy Holder Secondary Policy Holder

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: Self Spouse Child other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, and Zip: _____

MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

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 _____
- Do you need to pre-medicate? Yes No If yes, please explain: _____

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other: _____

Women:

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

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			
Do you have any sleep disorder (sleep apnea/snoring)?				Yes	No	If yes, do you wear a C PAP or any appliance?	Yes	No			

Continued



Welcome,

Our office screens all new patients for potential air flow disorders prior to any dental treatment. We also screen all existing patients periodically throughout the year. Please complete this form and return it to the front desk staff.

First Name: _____ **Last:** _____ **Gender: M or F**

Patient Health History: *Please check all that applies*

<input type="checkbox"/>	Type 2 Diabetes	<input type="checkbox"/>	History of stroke
<input type="checkbox"/>	Heavy snoring	<input type="checkbox"/>	Difficulty concentrating
<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	Restless sleep	<input type="checkbox"/>	Morning headaches
<input type="checkbox"/>	Daytime sleepiness	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Periodically stops breathing during sleep	<input type="checkbox"/>	Headaches/migraines
<input type="checkbox"/>	COPD	<input type="checkbox"/>	Clench or grind your teeth
<input type="checkbox"/>	Experience pain (head, jaw, neck, shoulder(s), arm(s), low back	<input type="checkbox"/>	Been in car accident over 8 mph or any trauma (sports, injury, fall) in the last year
<input type="checkbox"/>	History of smoking	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Have CPAP – I don't use it	<input type="checkbox"/>	Have CPAP – I use it

Below are 8 questions regarding sleepiness. Please circle only one answer per question. **Answer these questions as if it is your day off, you've had no stimulants, including caffeine, and you have the opportunity to relax.**

How Likely Are you To Fall Asleep While...

1. Sitting and reading?	0	1	2	3
2. Watching TV?	0	1	2	3
3. Sitting inactive in a public place (meeting, theater, etc)?	0	1	2	3
4. As a passenger in a car for an hour without a break?	0	1	2	3
5. Lying down to rest in the afternoon when circumstances permit?	0	1	2	3
6. Sitting and talking to someone?	0	1	2	3
7. Sitting quietly after lunch without alcohol?	0	1	2	3
8. In a car while stopped for a few minutes in traffic?	0	1	2	3

Score: _____

AUTHORIZATION TO USE / DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

Other names under which the Patient has been treated: _____

I authorize Drs. Estrada, Estrada-Mangaya, and Associates and its employees, agents or associated healthcare practitioners to use or disclose the Patient's protected health information as described below.

1. **Relevant Time Period.** Drs. Estrada, Estrada-Mangaya, and Associates may use or disclose information relating to healthcare provided during my time as an established patient.

2. **Types of Information.** Drs. Estrada, Estrada-Mangaya, and Associates may use or disclose the following type(s) of information:

- Any information concerning the Patient's healthcare or payment during the relevant time period.
- Medical records concerning the Patient's healthcare during the relevant time period, including:
Records from the Patient's chart (e.g., history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, etc.)
Diagnostic images, films or other recordings (e.g., x-rays, MRI scans, CT scans, etc.)
- Billing and payment records for healthcare rendered during the relevant time period.
- Other: _____

3. **Persons to Whom Disclosure Allowed.** Drs. Estrada, Estrada-Mangaya, and Associates may disclose the information to the following entity (ies):

Name and relation: _____

Address: _____

Phone number: _____

4. **Purpose.** Drs. Estrada, Estrada-Mangaya, and Associates may use or disclose the information for the following purpose(s):

- The disclosure is made at the Patient's request.
- For a potential or pending legal proceeding.
- For marketing. Drs. Estrada, Estrada-Mangaya, and Associates will not receive remuneration from a third party for the use or disclosure of the information.
- Other: _____

I understand that I have the right to revoke this authorization at anytime except to the extent that PROVIDER has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:

1354 Kempsville Rd. Suite 101, Chesapeake, VA 23320 or Fax: 757-548-1051

I understand that Drs. Estrada, Estrada-Mangaya, and Associates may not condition the Patient's healthcare on this authorization unless (1) the purpose for Drs. Estrada, Estrada-Mangaya, and Associates evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by Drs. Estrada, Estrada-Mangaya, and Associates pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

Signature

Date

Authority or relationship to the Patient

FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. Ultimately, however, You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

ALL PATIENTS ARE EXPECTED TO PAY IN CASH, CHECK, OR CREDIT CARD THE DAY SERVICE IS RENDERED, UNLESS SPECIFIC ARRANGEMENTS ARE MADE IN ADVANCE.

Insurance

For those patients covered by insurance, we will accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Most policies do not cover 100% of the cost of your treatment. Because of this, and the extreme delay in receiving payment from your insurance company, you will be asked to pay your deductible and your portion of the charges the day services are rendered. We will estimate, as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. Payment from your insurance company is not guaranteed until they process the claim. We will assist you in dealing with your insurance company, but ultimately the responsibility lies with you. If, after 45 days, the insurance company has not paid, the balance will be due, in full, by you.

_____ (Initials)

Missed Appointments

Missed appointments will cause a delay in your treatment. Please contact our office **no less than 48 hours prior** to your scheduled appointment. We try to keep our costs at a minimum; however, patients who do not show up for their reserved appointment will create undue costs to our office (the costs for the staff and their preparation of your treatment). Patients requesting emergency treatment may be seen at this available time. We will charge the normal fee for an office visit (**\$69.30 per hour**) if you fail to contact our office **48 hours prior** to your treatment. Your cooperation in the matter will be greatly appreciated. If patients are going to be more than 15 minutes late for their scheduled appointment, the office has the right to reschedule patient for another time so that other patients can be seen at their scheduled time.

_____ (Initials)

Deposit/Retainer Fees

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for reservations over 2 hours, we require a mandatory non-refundable 30% retainer fee at the time any major appointment is scheduled. This fee is applicable for crown, bridge, denture inlay/onlay appointments or any extensive treatment with an appointment time of 2 or more hours.

_____ (Initials)

Return Check Policy/Finance & Service Charges

In the event your check is returned unpaid for insufficient or uncollected funds, we may re-present your check electronically for the face amount of the check plus the posted return check charge (\$35.00) and any statutory fees allowed by law. If a payment arrangement is made and the funds are not available, you will receive one courtesy call. If the problem persists there will be a non-sufficient fee charge of \$35.00. Any balance left remaining in your account will be subject to a \$2.00 service charge, balances over 30 days will be subject to a 1.5% finance charge monthly until balance is paid in full. If there is a balance remaining for more than 90 days, the account will be sent to collection and/or court.

_____ (Initials)

If you have any questions, please feel free to ask your insurance company or us at any time. We wish to be of assistance in any way we can.

I HAVE READ AND THOROUGHLY UNDERSTAND DRS. ESTRADA AND MANGAYA'S OFFICE FINANCIAL AND CANCELLATION POLICY.

 Patient's Signature or Parent or Guardian if patient is a minor

 Date

 Witness Signature

 Date

NOTICE OF DEEMED CONSENT TO BLOOD TESTING

A new Virginia Law was enacted in 1989 that allows Healthcare Providers to test their patients for HIV antibodies when a healthcare worker is exposed to the blood or body fluids of a patient in a way, which may transmit human immunodeficiency virus (HIV), the virus that causes AIDS. Because of this Law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the exposed health worker. Except in emergencies, you will be informed before any of your blood is tested for HIV antibodies, the testing will be explained to you and you will be given the opportunity to ask any questions you might have. You will be provided with the test results and appropriate counseling.

Should an employee be exposed to my blood/body fluid in a way that might allow transmission of infection due to blood borne disease (e.g. HIV, Hepatitis etc.) or other communicable diseases; I understand that according to **Virginia State Law** for the safety, health and possible treatment of our employee, samples of my blood or body fluid may be tested for evidence of infection. Test results, if positive are required by law to be reported to the Virginia Department of Health.

I have read and understand the above Notice of Deemed Consent to Blood Testing.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If patient is under the age of 18)

Employee/Staff Signature: _____ Date: _____

INFORMED CONSENT TO PHOTOGRAPH

The Department of Health and Human Services has established a "Privacy Rule." The Privacy Rule was created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. Part of your treatment may include photographs of the face and teeth/smile. We may desire to use the photographs taken of you by our office for treatment, educational, and/or advertising purposes. However prior to using any photographs for advertising purposes we will obtain consent from the patient, parent, or legal guardian.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

I, _____, **do** / **do not** give consent for Dr. Estrada, Dr. Estrada-Mangaya, and Associates or staff to take and/or display photograph(s) of the face and teeth/smile of the patient's listed below. The photograph will be used for educational and/or advertising purposes by Estrada, Estrada-Mangaya and Associates Family Dentistry and may be displayed within our office and/or on the dental office's webpage, www.estradadds.com, or on the dental office's Facebook page, www.facebook.com/estradadentistry. The doctors and office and staff will protect the patient's personal data, such as name, age and date of birth, from being displayed.

Additional family members (if applicable):

Patient's Name: _____ D.O.B: _____

Patient's Name: _____ D.O.B: _____

Patient's Name: _____ D.O.B: _____

Printed Name: _____

Signature: _____ **Date:** _____

Relation to Patient:
 Self Guardian

Witness: _____ Date: _____