Esparza Family Dentistry

Patient Registration
(Please Print)

Date _____

Home Phone _____Work Phone _____Cell Phone _____

Patient Name _____
Last First Middle Int. Preferred Name

Address _____
Street City State Zip

Email Address_____ Age _____ DOB _____

Patient SS# _____ Marital Status S ___ M ___ D ___ W ___

Employer _____ Occupation _____

Primary Insurance

Name of Dental Insurance Co. _____

Member ID # _____ Group/Policy #_____

Guarantor's Name _____ SS# _____

Guarantor's Employment _____ Guarantor's DOB _____

Secondary Insurance

Name of Dental Insurance Co. _____

Member ID # _____ Group/Policy #_____

Guarantor's Name _____ SS# _____

Guarantor's Employment _____Guarantor's DOB_____

Emergency Contact _____
Name Phone Number

Whom should we thank for referring you? _____

I agree to be responsible for payment of all services rendered on my behalf or my dependents.
I understand dental insurance may pay less than the actual bill for services.

Signature of patient or parent, if minor _____

Relationship to Patient _____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐
Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Anemia
☐	☐	Sickle Cell Disease
☐	☐	Blood Transfusion
☐	☐	Hemophilia
☐	☐	Alcohol Abuse
☐	☐	Drug Abuse
☐	☐	Allergies
☐	☐	Sinus Problems
☐	☐	Artificial Heart Valve
☐	☐	Angina Pectoris
☐	☐	Congenital Heart Defect
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Mitral Valve Prolapse
☐	☐	Rheumatic Fever
☐	☐	Pace Maker
☐	☐	Joint Replacement
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Emphysema

Y	N	Conditions
☐	☐	Tuberculosis
☐	☐	Cancer- Chemotherapy
☐	☐	Radiation Therapy
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Seizures
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	Fever Blisters
☐	☐	HIV+ AIDS
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	Liver Disease
☐	☐	High Cholesterol
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Kidney Problems
☐	☐	Psychiatric Problems
☐	☐	Stroke
☐	☐	Thyroid Problems

Y	N	Conditions
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Pain In Jaw Joints
☐	☐	Past Or Recent Surgery
☐	☐	
☐	☐	

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Esparza Family Dentistry

Financial Policy

Our office is committed to providing you with the highest quality dental treatment and the best possible care. We are happy to discuss our professional services and related fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. We encourage you to ask questions regarding fees, the office financial policy and your account status. You are responsible for all fees related to your treatment. You are responsible for the timely payment of your account. **We expect either payment in full or your co-payment on the day of service**. We will file your insurance as a courtesy to you. If your insurance company has not paid your claim within 45 days you will be notified. You will be expected to pay your balance at that time. If the balance on your account is not paid in full within 60 days, your account will be forwarded to our collection service. Collection fees, court cost, attorney fees and any other fees would be your responsibility. In cases of disputes, you agree that venue and jurisdiction for all matters concerning our relationship shall be proper only in the courts of the City of Virginia Beach, Virginia**.**

If you cancel your scheduled appointment within less than 24 hours notice, or fail to come to your appointment, a $25 per appointment hour charge will be incurred.

Insurance

This office is a participating provider with Delta Premier and United Concordia (please note: we are not contracted with United Concordia's Tricare Dental Program). It is very important that you understand your insurance benefit is a contract **between you and your insurance company**. We will gladly file your claim as a courtesy to you. However, you are ultimately responsible for any and all fees related to your dental treatment. **If your insurance company denies payment for a service deemed necessary by the dentist, we will do our best to appeal but you are ultimately responsible for payment of services rendered.** Any grievances or concerns regarding coverage and benefits should be directed to your employer or dental insurance provider. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges and benefits other than to supply factual information.

In cases where a secondary insurance is involved, you will be required to pay the portion of your account balance that was not covered by your primary insurance. **If you have 3 or more insurances, we will file the primary and secondary insurances only; we can give you the information you need to file any additional insurances you have.**

This office does not participate in HMO's or DMO's. It is imperative that you discuss your co-payment obligation prior to treatment. Due to the significant discount from our normal fee with certain insurance companies, your account must be paid in full on the date of service, per your insurance contract.

I have read the above financial policy and understand the provisions of the agreement. I have had an opportunity to ask questions and have them answered to my satisfaction. By signing this agreement, I accept the terms, provisions and obligations of the financial policy of this office.

Note: *In the case of default on payment of this account, I agree to pay collection costs and attorney fees of 33 1/3% incurred in attempting to collect on this outstanding account balance.*

Signature of patient/responsible party: _____ Date: _____

Esparza Family Dentistry

AUTHORIZATION TO USE DISCLOSE PROTECTED HEALTH INFORMATION

Patient: _____Date of Birth:_____
Address: _____
_____
Telephone: _____

Other names under which the Patient has been treated:
_____

I authorize Sarah T. Esparza, DDS, PC and its employees, agents or associated healthcare practitioners ("PROVIDER") to use or disclose the Patient's protected health information as described below.

1. **Relevant Time Period.** PROVIDER may use or disclose information relating to healthcare provided during the following time period:
   Anytime.
   Healthcare provided between (*date*) _____ and (*date*) _____.

2. **Types of Information.** PROVIDER 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, *etc.*)

   Billing and payment records for healthcare rendered during the relevant time period.
   Other: _____

3. **Persons to Whom Disclosure Allowed.** PROVIDER may disclose the information to the following entity (ies):
   Name: _____
   Address: _____
   _____
   Phone number: _____
   Relationship _____

4. **Purpose.** PROVIDER 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.
   Other: _____

I understand that I have the right to revoke this authorization at any time 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:

Sarah T. Esparza, DDS, PC

I understand that PROVIDER may not condition the Patient's healthcare on this authorization unless (1) the purpose for PROVIDER's 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 PROVIDER 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