Dental Solutions of Miami
Dr. Juan Cardenas & Dr. Alvaro Maya

dentalcare.com

Health History Questionnaire

Your health history is very important to us. In order that we may provide you with the best possible dental services, please answer all questions completely and accurately as incorrect information may compromise your treatment. This Health History Questionnaire will become a part of your dental treatment record and is considered "Confidential."

Date _____

Last Name _____ First Name _____ ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Address _____

City _____ State _____ Zip _____

Telephone#: _____ E-mail Address: _____

Reason for today's visit: (circle) Examination/Cleaning Pain/Swelling Broken Tooth/Filling

Have you previously been treated for this problem or concern? (circle) Yes No

How long has this been a problem or concern? _____

Health History

Are you currently under the care of a physician? (circle) Yes No

Reason for last visit? _____

Date of last physical examination _____/_____/_____

Physician's Name _____ **Phone** (_____)_____

Address _____

City _____ **State** _____ **Zip** _____

Past Medical History

1. **Have you ever had a serious illness, operation, or been hospitalized?** If so, please explain:
   _____

2. **Has there been any change in your health in the last two (2) years?** (circle) Yes No
   If yes, please explain _____

3. **Have you ever had an allergic reaction?** To: (circle) Medication Food Latex Products
   Other: _____

4. **Have you ever had or been treated for:** (circle all that apply):

Blood Pressure: High or Low	High Cholesterol	Heart Disease	Stroke
Rheumatic Fever	Heart Murmur	Heart Valve	Fibromyalgia
Hepatitis	Diabetes	Depression	Tuberculosis
Immunocompromised Disease	Asthma	Bleeding/Clotting Disorder	Dry Mouth
Other:			

5. **Do you now or have you ever used tobacco?** (circle) Yes No
   If you currently use tobacco, are you interested in quitting? (circle) Yes No

6. **How many alcoholic drinks do you consume:** a day? _____ a week? _____ a month?_____

7. **For women:** **a. Are you pregnant or do you think you may be pregnant?** (circle) Yes No
   b. Are you taking birth control pills? (circle) Yes No

Current Medications: Prescribed and Over-the-Counter

	Name of Medication	Dose	Frequency
1.			
2.			
3.			

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Dental History

Last Name _____ First Name _____ ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Address _____

City _____ State _____ Zip _____

1. Date of last dental visit? _____/_____/_____ Date of last dental x-rays? _____/_____/_____
2. Reason for last visit? _____
3. Do you have any concerns about previous dental care or this dental visit? _____
   _____
4. **Do your gums bleed?** (circle) Yes No
5. **Are your teeth loose?** (circle) Yes No
6. **Have you ever been told you have gum disease?** (circle) Yes No
7. **Have you ever been told you have bad breath?** (circle) Yes No
8. **Are your teeth sensitive to?** (circle all that apply) Sweets Cold Heat Pressure
9. **Have your ever had any pain in your jaw joints (clicking, popping)?** (circle) Yes No
10. **Are you happy with your smile?** (circle) Yes No
    If no, please explain: _____
11. What would you change about the present condition of your mouth? _____

• • •

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature _____ **Date** _____

If you have completed this form for another person, please print your name and sign below along with your relationship to patient.

Print _____ **Relationship** _____

Signature _____ **Date** _____

Best # to reach you? _____ E-mail Address? _____

Health History Update: On a regular basis we will be asking about any changes in your medical history.

Date	Changes/Comments	Signature of Patient and Dentist
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____

Dental Solutions of Miami
7775 SW 87th Avenue
Suite 112
Miami, Florida 33173
Insurance information Form

❖ **Dental Primary Carrier:**_____
Address:_____
Telephone #:_____
Subscriber Name and Date of Birth_____
Subscriber ID (MAY BE SS#)_____
Group name and Number:_____
Patient name and date of birth:_____
Relationship to insured?:_____
Is patient full time student?:_____ **Is patient Disabled?**_____
If yes: Name of School:_____

❖ **Dental Secondary Carrier:**_____
Address:_____
Telephone #:_____
Subscriber Name and Date of Birth_____
Subscriber ID (MAY BE SS#)_____
Group name and Number:_____
Patient name and date of birth:_____
Relationship to insured?:_____
Is patient full time student?:_____ **Is patient Disabled?**_____
If yes: Name of School:_____

❖ **Medical insurance Carrier:**_____
Address:_____
Telephone #:_____
Employer:_____
Plan Type (HMO/PPO)_____
Subscriber Name and Date of Birth_____
Subscriber ID (MAY BE SS#)_____
Group name and Number:_____
Patient name and date of birth:_____
Relationship to insured?:_____
Is patient full time student?:_____ **Is patient Disabled?**_____
If yes: Name of School:_____

Dental Solutions Of Miami
7775 S.W. 87th Avenue
Suite 112
Miami, Florida 33173

Consent for Treatment (Initial Diagnostics)

My signature on the bottom of this form certifies that:

1. I give consent to Dr. Cardenas/Dr. Maya to evaluate the condition for which I present and to take any necessary steps, including radiographs, pictures, and models in order to diagnose and propose a course of treatment. The cost involved in the diagnostic process will be explained to me prior to starting.

2. I understand that I will be informed if any records that I may have brought with me can not be used by Dr. Cardenas/Dr. Maya for the purpose of the evaluation.

3. I understand that before any procedure, including diagnostic procedures such as x-rays, are performed I will be given an estimate for the cost and no procedure will take place without my consent.

4. I understand that once treatment has been decided, I will be given additional informed consent forms to review and sign prior to commencing said treatment.

5. I understand that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of prosthetic treatment or surgery can be made due to the uniqueness of every individual clinical situation. In most instances, the outcome of treatment is satisfactory.

What you are being asked to sign is a confirmation that you have read and understood this document. Please feel free to ask any questions you might have and we will gladly help you.

_____ _____

Patient Name Patient/Guardian Signature

_____ _____

Dr or Staff's Signature Date

Best # to reach you? _____

E-mail Address?_____

Acknowledgement of Receipt of Privacy Practices

I,_____ have received a copy of JUAN DIEGO CARDENAS, D.D.S. Notice of Privacy Practices with an effective date of 04/16/03.

Name of Patient _____

Address of Patient _____

Signature of Patient _____Date_____

Name of Witness _____

Signature of Witness _____Date_____

Dental Solutions of Miami Financial Policy for Patient Issue

Thank you for choosing us as your dental health care provider. We are committed to providing you with the best possible dental care at the lowest possible cost. In order to achieve these goals, we need your assistance, and your understanding of our payment policy:

FULL PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS. **WITH PRIOR APPROVAL**, WE ALSO OFFER A CHOICE OF INTEREST-FREE OR EXTENDED PAYMENT PLANS THROUGH CARECREDIT, SPRINGSTONE, AND CHASE ADVANTAGE.

Returned checks and balances older than 30 days may be subject interest charges of 1.5% per month. Accounts with balances over 90 days might be subject to legal action.

If you have insurance coverage, we will be glad to help you receive your maximum allowable benefits and will file the claim for you upon request. In most instances we will accept assignment of insurance benefits, however, we may require a co-payment at the time of service. The entire balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. Hence, the insurance company is responsible to you and you are responsible to us.

By law your insurance carrier must remit payment or deny your insurance claim within 30 days of initial notice of claim. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problem. If your insurance company has not paid your account in full within 45 days, the balance may be transferred to your credit card or Credit plan.

Please be aware that few insurance companies attempt to cover all dental costs. To avoid disappointment, we strongly suggest that you contact your insurance company to make certain your dental insurance assumptions are correct. Some pay fixed allowances for each procedure while others pay only a percentage of the costs. Our practice is committed to providing the best treatment for all of our patients, whether they have insurance or not, and we charge what is usual and customary for dental specialists in the Miami area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates, which may bear no relationship to the current standard and cost of care in this area.

Our staff is happy to help you with any insurance question you may have. Remember, though, that we can best answer questions relating to how your claim was filed, or regarding any additional information the carrier might need to process your claim. COVERAGE ISSUES can only be addressed by your employer or group plan administrator. Although our assistance is available to you at any time, we cannot act as a mediator with the carrier or your employer.

In our best efforts to accommodate all of our patients we ask that if circumstance arise that prevent you from attending your dental appointment please be so kind as to provide us with 48 hours notice to avoid incurring a $50.00 missed appointment fee.

Our practice firmly believes that a good dentist/patient relationship is based upon understanding and good communications. Thank you for understanding our Financial Policy. If you have any questions about financial arrangements, please feel free to talk with our office manager. We will make every effort to clarify any misunderstanding you have concerning your balance. We are here to help you.

I have read, understand and agree to the Financial Policy:

_____ _____

Signature of Patient or Responsible Party Date

Dental Solutions of Miami
Dr. Juan Diego Cardenas
Dr. Alvaro Maya

7775 SW 87th Avenue
Suite 112
Miami, Florida 33173
305-598-9072

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Dental Solutions of Miami
7775 SW 87th Ave Suite 112
Miami, Florida 33173
305-598-9072
info@dentalsolutionsofmiami.com
Contact person: Diane Dominguez

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

09/13

This Notice of Privacy Practices applies to the following organizations.

Dental Solutions of Miami
7775 SW 87th Ave Suite 112
Miami, Florida 33173
305-598-9072
info@dentalsolutionsofmiami.com
Contact person: Diane Dominguez

Instruction H: Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.