Patient Information

Date: _____ Time: _____

Patient is: ☐ Policy Holder ☐ Responsible Party

Patient Name: _____
First Name

_____ _____
Middle Initial Last Name

E-Mail: _____

☐ Yes, I would like to receive appointment reminders and correspondences via email from Sun City Dental.

Address: _____

City: _____

State/Zip code: _____

Cell Phone: _____

☐ Yes, I would like to receive appointment reminders via Text Messages from Sun City Dental.

Home Phone: _____

Work Phone: _____ Ext# _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Divorced ☐ Separated ☐ Partnered for _____ years

Birth date: _____ Age: _____

Soc. Sec: _____

Driver License: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Patient Employer/School _____

Employer/School Address: _____

_____

Employer/School Phone: _____

Emergency Contacts:

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Who may we thank for referrine: you?

Referred by: _____

Dental Insurance

Who is responsible for this account?

Name of Insured: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec: _____ Birth Date: _____

Ins. Company: _____

Group/Member ID #: _____

Ins. Company Address _____

City, State, Zip: _____

Insured Employer: _____

Address: _____

_____

City, State, Zip:. _____

Is patient covered by additional insurance? Yes ◯ No ◯

Name of Insured: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec: _____ Birth Date: _____

Ins. Company: _____

Group/Member ID #: _____

Insured Employer: _____

Address: _____

_____

City, State, Zip: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. Iven Gonzalez all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may usc my health care information and may disclose such information to the above - named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian Or Personal Representative

_____

Please Print name of Patient, Parent, Guardian or Personal Representative _____

Date _____ Relationship to Patient _____

Dental History

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Data or last dental X- rays _____

Place a mark on "yes" or "no" to Indicate if you have had any of the following:

Bad breath	Yes ◯	No ◯
Bleeding gums	Yes ◯	No ◯
Blisters on lips or mouth	Yes ◯	No ◯
Burning sensation on tongue	Yes ◯	No ◯
Chew on one side of mouth	Yes ◯	No ◯
Cigarette, pipe, or cigar smoking	Yes ◯	No ◯
Clicking or popping jaw	Yes ◯	No ◯
Dry mouth	Yes ◯	No ◯
Fingernail bittng	Yes ◯	No ◯
Food collection between the teeth	Yes ◯	No ◯
Foreign objects	Yes ◯	No ◯
Grinding teeth	Yes ◯	No ◯
Gums swollen or tender	Yes ◯	No ◯
Jaw pain or tiredness	Yes ◯	No ◯
Lip or cheek biting	Yes ◯	No ◯
Loose teeth or broken fillings	Yes ◯	No ◯
Mouth breathing	Yes ◯	No ◯
Mouth pain. brushing	Yes ◯	No ◯
Orthodontic treatment	Yes ◯	No ◯
Pain a round ear	Yes ◯	No ◯
Periodontal treatment	Yes ◯	No ◯
Sensitivity to cold	Yes ◯	No ◯
Sensitivity to heat	Yes ◯	No ◯
Sensitivity to sweets	Yes ◯	No ◯
Sensitivity when biting	Yes ◯	No ◯
Sores or growths in your mouth	Yes ◯	No ◯

How often do you floss? _____

How often do you brush? _____

Signature:

Sun City Dental

Eaglesoft Medical History

Patient Name: _____ Birth Date: _____ Date Created: _____

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 _____

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

Have you ever had a senous head or neck injury? Yes ○ No ○ If yes _____

Are you taking any medications, pills, or drugs? Yes ○ No ○ If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes ○ No ○ If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes ○ No ○ If yes _____

Are you on a special diet? Yes ○ No ○

Do you use tobacco? Yes ○ No ○

Women: Are you... ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the folowng?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other? If yes _____

Do you use controlled substances? Yes ○ No ○ If yes _____

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

AIDS/ HIV Positive Yes ○ No ○	Cortisone Medicine Yes ○ No ○	Hemophilia Yes ○ No ○	Radiation Treatments Yes ○ No ○
Alzheimer's Disease Yes ○ No ○	Diabetes Yes ○ No ○	Hepatitis A Yes ○ No ○	Recent Weight Loss Yes ○ No ○
Anaphylaxis Yes ○ No ○	Drug Addiction Yes ○ No ○	Hepatitis B or C Yes ○ No ○	Renal Dialysis Yes ○ No ○
Anemia Yes ○ No ○	Easily Winded Yes ○ No ○	Herpes Yes ○ No ○	Rheumatic Fever Yes ○ No ○
Angina Yes ○ No ○	Emphysema Yes ○ No ○	High Blood Pressure Yes ○ No ○	Rheumatism Yes ○ No ○
Arthritis/Gout Yes ○ No ○	Epilepsy or Seizures Yes ○ No ○	High Cholesterol Yes ○ No ○	Scarlet Fever Yes ○ No ○
Artificial Heart Valve Yes ○ No ○	Excessive Bleedmg Yes ○ No ○	Hives or Rash Yes ○ No ○	Shingles Yes ○ No ○
Artificial Joint Yes ○ No ○	Excessive Thirst Yes ○ No ○	Hypoglycemia Yes ○ No ○	Sickle Cell Disease Yes ○ No ○
Asthma Yes ○ No ○	Fainting Spells/ Dizziness Yes ○ No ○	Irregular Heartbeat Yes ○ No ○	Sinus Trouble Yes ○ No ○
Blood Disease Yes ○ No ○	Frequent Cough Yes ○ No ○	Kidney Problems Yes ○ No ○	Spina Bifida Yes ○ No ○
Blood Transfusion Yes ○ No ○	Frequent Diarrhea Yes ○ No ○	Leukemia Yes ○ No ○	Stomach/Intestinal Disease Yes ○ No ○
Breathing Problems Yes ○ No ○	Frequent Headaches Yes ○ No ○	Liver Disease Yes ○ No ○	Stroke Yes ○ No ○
Bruise Easily Yes ○ No ○	Genital Herpes Yes ○ No ○	Low Blood Pressure Yes ○ No ○	Swelling of Limbs Yes ○ No ○
Cancer Yes ○ No ○	Glaucoma Yes ○ No ○	Lung Disease Yes ○ No ○	Thyroid Disease Yes ○ No ○
Chemotherapy Yes ○ No ○	Hay Fever Yes ○ No ○	Mitral Valve Prolapse Yes ○ No ○	Tonsillitis Yes ○ No ○
Chest Pains Yes ○ No ○	Heart Attack/Failure Yes ○ No ○	Osteoporosis Yes ○ No ○	Tuberculosis Yes ○ No ○
Cold Sores/ Fever Sisters Yes ○ No ○	Heart Murmur Yes ○ No ○	Pain in Jaw Joints Yes ○ No ○	Tumors or Growths Yes ○ No ○
Congenital Heart Disorder Yes ○ No ○	Heart Pacemarker Yes ○ No ○	Parathyroid Diseasa Yes ○ No ○	Ulcers Yes ○ No ○
Convulsions Yes ○ No ○	Heart Trouble/ Disease Yes ○ No ○	Psychiatric Care Yes ○ No ○	Venereal Disease Yes ○ No ○
			Yellow Jaundice Yes ○ No ○

Have you ever had any serious illness not listed Yes ○ No ○ If yes _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, or Guardian: _____ Date: _____

Signature:

Sun City Dental, PLLC
11240 Montwood Dr. Suite J El Paso, TX 79936
Ph: (915) 201-2539 Fax: (915) 613-5082

Office Policies

Thank you for reviewing the following office policies. We commit to putting forward our best efforts to provide you with the most up to date, skilled, and compassionate dental care possible. In return we respectfully ask you to agree to the following:

Missed Appointment Policy - Please Initial

- Dr. Gonzalez reserves your appointment time exclusively for you. If you need to reschedule your appointment, we kindly ask you to please call our office 48 hours prior to your scheduled appointment so that another patient may have your appointment time. A fee of $50 fee will be charged to your account for rescheduling, cancelling, or failing to show up for your appointment without a prior 48 business hours notice.
- If you are more than 15 minutes late, you may be asked to reschedule. A $30.00 fee may also be charged to your account upon 2 consecutive appointments where you come in late 15 minutes or more.

Office Fees Policy - Please Initial

- Payment for services is due at the time of office visit. Payment options include Cash, MasterCard, Visa, American Express, Discover, and Care Credit.
- As a courtesy to our patients, we file all claims to the insurance company. The patient is expected to pay all charges not covered by the insurance at the date of service. If the insurance does not pay a claim, the patient will be responsible for charges and will be billed.
- Any balance remaining after your insurance has paid will be due within 30 days. If payment is not received your account may be referred to a collections agency.
- Your dental insurance benefits are verified by our office according to information provided by you. The benefits quoted by your insurance company are just an estimate and are NOT A GUARANTEE OF COVERAGE. You will be responsible for any amount not covered.
- Please be aware that some insurance companies downgrade the price of composite fillings to the amalgam price. Our office compensates for this by adjusting the percentages for restorative work. It is your responsibility to confirm with your insurance if we are in or out of your network, and if the service you request is covered by your insurance.
- All co-pays, co-insurance, and deductibles must be paid at the time of service. Any accounts with outstanding balances must be paid prior to any additional services being rendered.
- A $40.00 charge will be added to your account for any returned checks.

We look forward to having you as our patient!

I HAVE READ AND ACCEPT THE OFFICE POLICIES. I ALSO UNDERSTANDTHAT I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES INCURRED FOR DENTISTRY PERFORMED UPON MYSELF IN THIS DENTAL PRACTICE.

Print Name: _____

Signature: _____ Date: _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I have received a copy of Sun City Dental, PLLC Notice of Privacy Practices.

Print Patient's Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Staff Signature _____ Date _____

HIPAA Authorization for Release of Protected Health Information

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

Privacy Official: Dr. Iven Gonzalez, DDS

Dental Practice mailing address: 11240 Montwood Dr. Suite J, El Paso, TX 79936

Dental Practice email address: suncitydental@ live.com

Dental Practice phone number: (915) 201-2539

Protected Health Information that I am authorizing the Dental Practice to release (Please check the records to which this Authorization applies):

I authorize Sun City Dental, PLLC and its employees to release the following Protected Health Information:

- ☐ Dental reports and notes.
- ☐ Dental Images
- ☐ All dental records relating to (specify injury or illness): _____
- ☐ Other(specify): _____

The reason for the release of the Protected Health Information (please check the reason(s) that apply):

- ☐ Patient Request
- ☐ Review Patient's current care
- ☐ Treatment/continued care
- ☐ Payment for care, including insurance

• Please be advised, if you wish we not disclose your PHI to your insurance carrier for purposes of payment to services rendered, payment for services will be due in full the day of the appointment. Request to withhold information from your insurance carrier must be done at your new patient appointment or before treatment commences. It may not be possible to withhold information from your insurance carrier after treatment has commenced or request to share for certain procedures and not for others whether or not procedures were performed the same day, as your insurance carrier may still be able to deduce this information You are still responsible for any balance due as a result of non-payment from your insurance company for services rendered.

- ☐ Legal
- ☐ Obtaining Social Security Disability or other public benefits
- ☐ Other (specify): _____

Your rights with respect to this Authorization:

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization; however, payments for services will be due in full the day of the appointment.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to the Dental Practice to the address or email address indicated on the first page of this Authorization. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

Please Print Patient's Name _____ Date _____

Signature of Patient, Parent, Guardian Or Personal Representative _____

Authority of Personal Representative to Sign for the Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please print name of Parent, Guardian or Personal Representative _____

Signature:

Print