

Parra Family Dentistry

<https://www.parrafamilydentistry.com/>

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Welcome to Parra Family Dentistry

Chart#: _____

FOR OFFICE USE ONLY

Patient Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: _____ - - - - - Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2

City State Zip Code

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Primary Dental Insurance:

Name of Insured: _____
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Birthday: _____

SSN: _____

Insurance Company Address and Phone Number:

Insurance Subscriber ID and Insurance Group Number:

Secondary Dental Insurance

Name of Insured: _____
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Company Address and Phone Number:

Insurance Subscriber ID and Insurance Group Number:

Insurance Authorization:

- By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all changes whether or not paid by insurance.

Signature _____ Date _____

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Allergy-Amox | <input type="checkbox"/> Allergy-Codeine | <input type="checkbox"/> Allergy-Hay Fever |
| <input type="checkbox"/> Allergy-Latex | <input type="checkbox"/> Allergy-Penicillin | <input type="checkbox"/> Allergy-Sulfa | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bisphosonates Meds |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epi Caution | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Growths | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pre-Med | <input type="checkbox"/> Pre-Med-Amox | <input type="checkbox"/> Pre-Med-Clind |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Smoker | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease |

- | | |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury) | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Taking medication for weight control (ie fen-phen) | <input type="checkbox"/> Taking dietary supplements |
| <input type="checkbox"/> Subject to frequent headaches | <input type="checkbox"/> A smoker or smoked previously |
| <input type="checkbox"/> FEMALE: Taking birth control pills | <input type="checkbox"/> FEMALE: Pregnant |

If any conditions or alerts selected above needs further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and/or vitamins taken within the last two years:

Dental Information

How would you rate the condition of your mouth?

- Excellent Good Fair Poor

What is your immediate concern?

Personal History, Check all that apply:

- Had an unfavorable dental experience
- Had trouble getting numb
- Had/have braces, orthodontic treatment
- Had any teeth removed
- Had complications from past dental treatment
- Had any reactions to local anesthetic
- Had your bite adjusted

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

HIPAA Acknowledgement

My personal health is private and confidential. I understand that my doctor and his/her staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his/her staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care

operations. I understand that my doctor may deny my request. If my doctor does agree to my request, I understand that my doctor and his/her staff would follow that agreed limits.

1. Signing and dating a written request to your doctor specifying what information you wish to restrict and to whom the restriction applies. You will receive a written response to your request.
 2. Writing, sign, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.
- If I cancel this consent, my doctor and staff do not have to provide any further health care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice".

If I ask, my doctor will provide me with the most current "Notice" and the current "Notice" will always be available at my doctor's office.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature _____ Date _____

Response Date:

____/____/____