

ROCA DENTAL

Name: _____
Last First MI Title
Preferred Name: _____ Male Female
Address: _____ City _____ State _____ ZIP _____
SSN: _____ DOB: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail Address: _____
Employer: _____ Occupation: _____
Marital Status: Single Married Divorced Widowed Separated Domestic Partner
How did you hear about our office? _____

■ Insurance – Primary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ ID Number: _____ Group Number: _____

■ Insurance – Secondary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ ID Number: _____ Group Number: _____

■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign all insurance benefits directly to Roca Dental. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____
Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

We welcome and value you as part of our dental practice. In order to avoid confusion regarding our financial and insurance policies; please review this document and sign it as acceptance and understanding of what is stated. Our practice accepts cash, check, VISA, MC, and Discover.

Today's dental plans are designed to assist patients with dental treatment. It is important to remember that necessary services are not necessarily covered. Our goal as your dental care provider is to make sure you have healthy teeth long after you change dental plans. It is your employer who chooses your benefits and how they are paid by the insurance company.

Please initial the scenario that describes your financial/insurance situation:

All outstanding balances are due within 90 days from date of service.

_____ I do not have dental insurance. I am responsible to pay my bill in full at each visit. The practice's personnel will give me information on outside financing, if I request it.

_____ I understand the practice's doctors are participating providers for my dental plan. I am required to pay my estimated portion of the dental fee at each visit for the treatment rendered that day. The amount I will be required to pay will be explained to me prior to my appointment. I also understand that my insurance is an agreement between the insurance company and me; therefore if the practice does not receive payment from my company in 90 days, the insurance balance for my account will be transferred to me personally.

_____ I understand the practice's doctors are not a participating provider for my dental benefit company and they will be waiting for the assignment of benefits as a courtesy to me. I understand I am responsible for my account regardless of my insurance status. I also understand that my insurance is an agreement between the insurance company and me; therefore if the practice does not receive payment from my company in 90 days, the insurance balance for my account will be transferred to me personally.

■ All major dental treatment must be paid in full prior to being inserted in your mouth. If I have insurance that the practice accepts, I must pay my portion in full as estimated by the office.

■ I must respect doctor/hygienist's schedule and will give 24 hours notice if I need to change my appointment time otherwise I may be charged \$ 50 for the loss of appointment time.

I have read and understand the statements listed above. I have read and received copy of this offices HIPPA privacy statement.

Patient's Signature

Date

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Do you have a personal physician? Yes No

Physician's Name: _____

Physician's Phone: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

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

Please explain: _____

Do you use tobacco in any form? Yes No

Have you had any metal rods, pins or implants placed? Yes No

Are you taking any medications? Yes No Please list each one: _____

Have you ever had any surgical procedures? Yes No Please list each one: _____

Do any of the following apply:

- | Yes | No | Conditions |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Facial Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |

- | Yes | No | Conditions |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | HIV+ AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis C |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |

- | Yes | No | Conditions |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |

- | Yes | No | Allergies |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline |

- | Yes | No | If Female, Please Answer |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking Birth Control Pills? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?
If so, # of Weeks _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing? |

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Patient's Signature

Date

ROCA DENTAL

How may we help you today? _____

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had gum treatment? Yes No

Have you ever had any pain/discomfort in your jaw joint? (TMJ) Yes No

Are you under stress? (new job, moving, relationships) Yes No

Do you like your smile? Yes No

Is there anything you would like to change about your smile? Yes No

Are you happy with the color of your teeth? Yes No

Do your gums bleed? Yes No

How many times do you: floss _____ brush _____

Are your teeth sensitive to heat, cold or anything else? Yes No

Have you lost any teeth? Yes No

Have you ever had a serious/difficult problem with previous dental work? Yes No

Have you ever had any unfavorable dental experiences? Yes No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Roca Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below that you would like our friendly staff to discuss with you during your visit.

Tooth Whitening

Veneers/Lumineers

Invisalign

Dental Implants

Smile Makeover

Bonding

Sealants

Crown and Bridge

Crown in 1 appointment

Partials/Dentures

Night/Sport Guards