"Welcome to Smiles in Miramar Dental!"

Patient's first Name_____ Last Name: _____ Middle Initial_____

Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

DOB: _____ Age: _____ Soc. Sec: _____

Male ( ) Female ( ) Email: _____ May we contact you via e-mail? Y N

Contact Name In Case of Emergency:_____ Relationship:_____ Phone:_____

Ref by: Insurance Co ( ), Walk in ( ), Internet ( ), Patient (_____)

Responsible Party

Relationship: Spouse ( ) Child ( ) Other ( )

First Name: _____ Last Name: _____Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

DOB: _____ Age: _____ SSN _____

Insurance Information

Policy Holder is Patient ( ) Other ( )

Name of Insurance Co. _____

Policy Holder_____ Birthdate_____ Soc Sec_____

Person Responsible Employed by: _____

Policy #: _____ Group ID #: _____

Phone: _____

Dental History (Confidential)

Reason for Today's Visit_____ Date of last dental care_____

Check if you have any problems with the following

□Bad Breath □Grinding teeth □Sensitivity to hot/cold □Sensitivity to sweets □Sensitivity when biting

□Sores or growth in your mouth □Bleeding gums □Clicking or popping jaw □Food Collection between teeth

□Loose teeth or broken fillings

How often do you floss? _____ How often do you brush?_____

Patient Agreement

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Dr. Rosado-Sage 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 name doctor may use my healthcare information and may disclose such information to the above named Insurance company and their agents for the purpose of obtaining payments for services determining insurance benefits or the benefits payable or related services. I have read and understand the information outlined above and have discussed any questions I may have with the office staff

Sign: _____ Date: _____

"We love to see you Smile."

Financial Policy

In an effort to keep our fees reasonable and to continue to provide quality care, we have established the following payment policy:

1. **All treatment will be paid in FULL at the time treatment is rendered.**
2. **Cash, Checks or Credit Cards are all acceptable forms of payment. We also accept Care Credit and Citi Health Card.**

*****We have our financial consultant who will be happy to help you with your individual needs*****

FOR THOSE PATIENTS WITH DENTAL INSURANCE

Smiles in Miramar Dental is happy to bill your insurance carrier. We do, however, require payment of any uncovered services, deductibles, or co-payments to be paid by you at each appointment.

You will be given an estimate based on the information your insurance provides to our office before any treatment outlining your financial responsibilities.

We reserve the right to charge a $40.00 return check fee. We kindly ask that you give at least 48 hour notice should you not be able to make your appointment or a $25.00 Cancellation/ Re-schedule or No Show fee applies.
Due to the overwhelming demand for Saturday appointment there will be no exceptions in regards to our fees and after 2 changed Saturday appointments we will not be able to extend Saturday appointments to you.

Remember, our staff is here to help make your visit with us a pleasurable one. Please do not hesitate to ask any questions or voice any concerns that you may have. We value you as our patient and thank you for choosing Dr. Itza M Rosado as your dentist.

I have read and understand the financial policy outlined above.

_____ _____

Signature of patient Date

Smiles in Miramar
Dentistry & Orthodontics

Signing this form is mandatory before being seen in this practice.

Cancellation Policy

Our office strives to reserve dental appointments that accommodate your personal schedule as much as possible. Should you be unable to keep your reserved appointment, we reserve the right to request sufficient notice (48 hours)- so that we may appoint someone else that is waiting for our care. Otherwise we reserve the right to charge a $25.00 cancellation fee that must be paid before further appointments are made in this office. Furthermore, should you cancel or re- schedule your Saturday appointment more than twice we will no longer be able to extend the courtesy of Saturday Appointments.

Thank you for your consideration in this matter.

Patient Signature_____ Date_____

Please be advised that due to demand for Saturday appointments we strictly enforce the cancellation fee should the appointment be broken- there will be no exceptions!!

Smiles in Miramar
Dentistry & Orthodontics

ACKNOWLEDGEMENT RECIEPT OF NOTICE OF PRIVACY PRACTICES

PATIENT AKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION.

I acknowledge that there was a copy of the Notice of Privacy Practices posted, describing how my health information may be used or disclosed under the federal law. Provided that "Itza M Rosado, D.D.S" continues in its good faith effort to comply with the requirements of the federal privacy act law, I hereby consent to use and disclosure of my health information for the purposes and the activities permitted under the federal privacy law which are described in the Notice of Privacy Practices.
I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by calling (954)433-2225, or by requesting one while at your office.

I also authorize Itza M Rosado, D.D.S and Staff to release all medical information to the following:

Name:_____ Relationship_____

Name: _____ Relationship_____

I acknowledge that I received a copy of Dr Itza Rosado-Sage DDS Notice of Privacy Practices.

Patient _____

Signature _____ Date_____

----------OFFICE USE ONLY----------

I attempted to obtain signature from patient but was unable to as indicated below:

Reason: _____

Date: _____ Initial_____

Time 1:30 PM | Itza M. Rosado, DDS | Date 8/3/2020

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, c

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 serious 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	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ 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 Bleeding ◯ 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 Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ 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 above? ◯ 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, Parent or Guardian:

X Date:_____

"BIENVENIDO A SMILES IN MIRAMAR DENTAL!"

Nombre del Paciente _____ Apellido: _____Incial:_____

Dirección: _____

Ciudad:_____ Estado: _____ Codigo Postal: _____

Telefono: _____ Telefono del Trabajo: _____ Ext: _____ Celular: _____

Fecha de Nacimiento :_____ Edad: _____ Soc. Sec: _____

Correo Electronico : _____ Podemos contactarlo por correo electronico? SI NO

Contacto en Caso de Emergencia:_____ Relacion :_____ Telefono:_____

Quien le recomendo nuestros servicios ?_____

Responsable del Seguro Dental

Relación con el paciente :_____

Nombre : _____ Apellido: _____Inicial: _____

Direccion: _____

Ciudad, Estado, Codigo Postal : _____

Telefono: _____ Telefono del Trabajo: _____ Ext: _____ Celular: _____

Fecha de Naciemiento : _____ Edad: _____ SSN _____

Informacion del Seguro

Relacion con el Paciente :_____

Compañia de Seguro _____

Nombre del Suscriptor _____ Fecha de Nacimiento _____

Seguro Social _____

Persona Responsable Empleado por : _____

Numero de Poliza: _____ Grupo #: _____

Telefono del Seguro: _____

Historia Dental (Confidencial)

Motivo de la Visita de Hoy _____ Fecha de su ultima visita Dental _____

Revisar si tiene alguno de estas molestias

□Mal aliento □Rechina los dientes □Sensibilidad a lo caliente/ frio □Sensibilidad a los dulces Sensibilidad cuando muerde

□Ampollas en labio o boca □Encias Sangrantes □clics en la Mandibula □ Coleccion de alimentos entre los dientes

□Dientes Sueltos o Empastes Rotos

Que tan seguido se pasa el hilo dental? _____

Que tan seguido se cepilla los dientes?_____

Convenio Del Paciente

Yo , El suscrito tengo seguro con _____ y transpaso directamente al Dr._____ todos los beneficios del seguroSign: _____ Date: _____

"We love to see you Smile."