"Teeth Are Our Business"

MICHAEL TENORIO, D.D.S.

Name(Last ,First,Initial) ______________________________

Home Phone ______________ Cell Phone ______________ Gender Male ○ Female ○

Mailing Address ______________________________

City ______________ State ______________ Zip ______________

E-mail address ______________ Birth Date ______________ Driver1s License No. ______________

☐ Yes, I can be contacted by e-mail

Minor ○ Single ○ Married ○ Widowed ○ Separated ○ Divorced ○

Do you desire to change or enhance your smile? ______________ If so,how? ______________

Present Position (patient) ______________ How long? ______________

Employer ______________ Bus. Phone & Ext. ______________

Name of Spouse/Parent ______________ Employer ______________ How long? ______________

Person Responsible for Account ______________ Relationship ______________

Insurance Co. ______________ Policy No. ______________

Patient's Social Security No. ______________ Spouse/Parent Social Security # ______________

Referred by ______________________________

Chief Dental Complaint ______________________________

GENERAL HEALTH

In the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Has there been any change in your general health within the past year? Yes ○ No ○

Your last physical examination was on ______________________________

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

If so what is the condition treated? ______________________________

The name of your physician is ______________________________

Have you had any serious illness or operation? Yes ○ No ○

If so, what was the illness or operation? ______________________________

Have you been hospitalized or had a serious illness within the past five (5) years?. Yes ○ No ○

What was the problem? ______________________________

Date of last dental exam? ______________ Date of last dental X -rays? ______________

How often do you brush? ______________ How often do you floss? ______________

Please check any of the following conditions that apply to you:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

1. Does your medical history indude any of the following conditions?

Heart Trouble	Yes ○ No ○
Pacemaker, Artificial Valves, Bypass (If Yes, which one?) ______________	Yes ○ No ○
Radiation/Chemotherapy	Yes ○ No ○
Stroke	Yes ○ No ○
High Blood Pressure	Yes ○ No ○
Low Blood Pressure	Yes ○ No ○
Rheumatic Fever	Yes ○ No ○
Dizziness or Fainting Spells	Yes ○ No ○
Frequent Mild or Severe Headaches	Yes ○ No ○
Sinusitis, Hay Fever, Asthma (If Yes, which one?) ______________	Yes ○ No ○
Diabetes	Yes ○ No ○
Thyroid Condition	Yes ○ No ○
Bleeding Disorders	Yes ○ No ○
Autoimmune Deficiency Syndrome(AIDS)	Yes ○ No ○
Does Your Jaw Click Out of Joint	Yes ○ No ○
Artificial Joints	Yes ○ No ○
Kidney or Bladder Trouble	Yes ○ No ○
Ear Trouble	Yes ○ No ○
Epilepsy or Convulsions	Yes ○ No ○
Do You Smoke?	Yes ○ No ○
Anemia	Yes ○ No ○
Tuberculosis	Yes ○ No ○

Hepatitis or Jaundice	Yes ◯ No ◯
Venereal Disease/STD's	Yes ◯ No ◯
Cancer	Yes ◯ No ◯
Psychiatric Care	Yes ◯ No ◯
Addiction to Drugs/Alcohol (If Yes, which one?) ______	Yes ◯ No ◯
Have You Ever Been Told You Have Pyorrhea, Periodontal Disease?	Yes ◯ No ◯
Have You Ever Had Periodontal Surgery? Date ______	Yes ◯ No ◯
Female Patient: Are You Pregnant? Month Due ______	Yes ◯ No ◯
Are You Taking Birth Control Pills?	Yes ◯ No ◯
Special Diet(?)	Yes ◯ No ◯
Ever Taken Bisphoshonate Drugs, i.e. Aredia, Fosamax. Boniva, Actonel?	Yes ◯ No ◯

(Dr. Comments) ______

2. Are you taking any of the following drugs?

Antibiotics or Sulfa Drugs	Yes ◯ No ◯
Anticoagulants (Blood Thinners)	Yes ◯ No ◯
Medicine For High Blood Pressure	Yes ◯ No ◯
Cortisone (Steroids)	Yes ◯ No ◯
Tranquilizers (Librium, Valium)	Yes ◯ No ◯
Antihistamines	Yes ◯ No ◯
Codeine/Or Pain Medications	Yes ◯ No ◯
Insulin	Yes ◯ No ◯
Digitalis or Drugs For Heart	Yes ◯ No ◯
Nitroglycerin	Yes ◯ No ◯
Decongestant	Yes ◯ No ◯
Other ______	Yes ◯ No ◯

Please list your specific medications:

______

3. Are you allergic or have you reacted adversely to any of the following?

Local Anesthetic (Novocaine Xylocaine)	Yes ◯ No ◯
Penicillin or Antibiotic	Yes ◯ No ◯

Please list ______

Barbiturates,Tranquilizers,Sleeping Pills	Yes ◯ No ◯
Aspirin or Anti-Inflamatories	Yes ◯ No ◯

Codeine or Similar Narcotic. Yes ○ No ○

Other ______________________________ Yes ○ No ○

4. Please comment on any medical problem not covered above.

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ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to provide you the best possible cares. If you have a dental insurance policy, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, American Express, Discover, Mastercard, Visa or Care Credit. We will be happy to process your insurance and in many instances can accept assignment of insurance benefits directly to our office. Should your insurance not assign benefits to our office, you will be responsible for full payment at the time of services and we will happy to process your insurance claim-form for your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We can only per-estimate your co-payment based on the perception of your policy.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R" is defined as usual, customary and reasonable fees for the region. Thus, our fees are considered usual, customary and reasonable by most companies.

   This statement does not apply to companies who reimburse based an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we gladly extend to our patients, all charges are your responsibility from the date the service are rendered. We realize temporary financial problems may affect timely payment of your account.
If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Note:
Returned Checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 1/2% per month. We do not accept out of town checks. Charges may also be incurred for broken appointments and appointments cancelled without a 24 hour notice.

I have read and understand above stated financial arrangements and insurance policies.

Signature ______________________________ Date ____________________