Alfredo M. Gapuz, Jr., DMD
Dentistry with a Gentle Touch

PATIENT REGISTRATION

Patient Information: **Date:** _____

First Name:_____ Middle Initial:_____ Last Name:_____

Birthdate:_____ Age:_____ Sex: F ___ M ___ SSN:_____ Driver Lic.:_____

Occupation:_____ Employer/School:_____

Marital Status: Single____ Married____ Divorced____ Separated____ Widowed____ Partnered____ Minor____

Address:_____

City:_____ State:_____ Zip Code:_____ Work Phone:_____ Ext _____

Home Phone:_____ Cell Phone:_____ I approve text message appointment remainder: YES / NO

e-mail:_____ I would like to have email correspondences: YES / NO

Emergency Contact: Name: _____ Relationship: _____

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

Insurance Information:

Name of Insured:_____ DOB:_____ SSN:_____

Relationship to patient:_____ Secondary Insurance? YES / NO

Insured's Employer:_____ Employer Phone:_____

Insurance Company: _____ Insurance Phone:_____

ID Number:_____ Group Number:_____

Please carefully read below:

I, the undersigned hereby authorize the doctor and personnel to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patients determined needs. I also authorize Aesthetic and General Dentistry to perform any and all forms of treatment, medication that may be indicated. I also understand that the use of local anesthetic agents embodies a certain risk and also will cause a section of my mouth to become numb, with the numbness lasting from a few minutes to several hours. I know that while my mouth is numb I must be carful not to bite my lips or tongue. I UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN ME, MY EMPLOYER AND THE INSURANCE COMPANY. MY GUARANTOR AND/OR I ARE RESPONSIBLE TO PAY FOR ALL CHARGES THAT ARE DENIED OR NOT COVERED BY MY INSURANCE COMPANY. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF THE SERVICE. I further understand that an additional charge will be added to any overdue balance. I have read and understand the financial policy and patient consent and privacy notice forms.

Patient or Guarantor Signature:_____ Date:_____

Wetness's Signature: _____ Date: _____

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Date:_____

Patient Name: _____ Date of Birth:_____ Age:_____

Physician Name:_____ Physician Phone:_____

Your current physical health is: Good_____ Fair_____ Poor_____

Do you take blood thinner? YES / NO If Yes, what medication:_____

Are you required to take premedication prior to dental procedures? YES / NO If Yes, what medication:_____

Please list **ALL** current medications or attach list: 1)_____ 2)_____

4)_____ 5)_____ 6)_____

Have you ever had a surgery where devices (ei. PINS, RODS, JOINTS, VALVES, etc.) were placed? YES / NO

Is YES, please give details:_____

Are you under a physician's care now? Yes / NO If Yes, please explain:_____

Are you ever been hospitalized or had major surgery? Yes / NO If Yes, please explain:_____

Do you take, or have you taken Phen-Fen or Redux? Yes / NO If Yes, please explain:_____

Do you use controlled substance? Yes / NO If Yes, please explain:_____

Do you use tobacco? Yes / NO If Yes, please explain:_____

Are you allergic to any of the following? Aspirin_____ Penicillin_____ Sulfa_____ Codeine_____ Iodine_____ Local Anesthetic_____

WOMEN: Are you: Pregnant_____ Nursing_____ Taking Oral Contraceptives_____ Do you have Osteoporosis YES / NO

If Yes, Are you taking medication for Osteoporosis? YES / NO What medication:_____

Do you have, or had any of the following:

__AIDS/HIV Positive	__Blood Transfusion	__Cortisone Treatment	__Hepatitis Type:___	__Nervous Problem	__Stroke
__Alzheimer's Disease	__Breathing Problem	__Cough, persistent / bloody	__Herpes	__Pacemaker	__Swollen Feet
__Anaphylaxis	__Bruise Easily	__Diabetes	__ High Blood Pressure	__Psychiatric Care	__Swollen Neck Gland
__Anemia	__Cancer	__Drug Addiction	__Psychiatric Care	__Radiation Treatment	__Thyroid Problem
__Angina	__Chemical Dependency	__Easily Winded	__Jaundice	__Respiratory Disease	__Tonsillitis
__Arthritis/Rheumatism	__Chemotherapy	__Emphysema	__Jaw Pain/TMJ	__Rheumatic Fever	__Tuberculosis
__Artificial Heart Valves	__Chest Pain	__Feinting Spells/Dizziness	__Kidney Disease	__Scarlet Fever	__Tumor on head/neck
__Artificial Joint	__Circulatory Problem	__Glaucoma	__Leukemia	__Sinus Trouble	__Ulcer
__Back Problem	__Cold Sores/Fever Blisters	__Hay Fever	__Liver Disease	__ Skin Rash	__Venereal Disease
__Bleeding abnormally	__Congenital Heart Lesions	__ Heart Problem	__Low Blood Pressure	__Special Diet	__Weight loss
__Blood Disease	__Convulsion	__Heart Murmur	__Mitral Valve Prolapse	__Spina Bifida	

Dental: How often do you floss?_____ How often do you brush?_____ Do you have dry mouth?_____ Do you want to keep your teeth?_____

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 health. It is my responsibility to inform the dental office of any changes in my medical status.

Patient's Signature: _____ Date:_____

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Patient Consent Form

The department of health and human services has established a Privacy Rule to help ensure that personal care information is protected for privacy. The privacy rule was created in order to provide a standard for certain providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum required information about treatment, payment or health care operations.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients) and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to use or disclose your health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your **Personal Health Information (PHI).** If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA compliance officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient and/or Guarantor Signature: _____

Patient's Name: _____ Date: _____

Witness's Signature: _____ Date: _____

Aesthetic and General Dentistry
14009 Egret Tower Drive
Orlando, FL 32837
(407)251-5100
www.AMGsmile.com

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DENTAL BILLING PROCESS INFORMATION

Thank you for choosing Aesthetic and General Dentistry. In an effort to better serve you, we would like to take the time to explain the Insurance billing process at our office.

We accept most insurance plans and will gladly process your claim. Please bring the necessary insurance and billing information with you to your visits. Insurance policies generally cover only a portion of the total treatment cost. Unless other arrangements have been made, we ask that you pay the portion of the bill not covered by your insurance company at the time of your treatment.

Once you provide the office with your dental insurance information, we call the insurance company and verify your benefits. The information we receive from the insurance company is only an estimate on coverage and not a guarantee of coverage. After you have been seen in our office, we will file the claim to the insurance company directly. If the insurance company does not cover the estimated amount in full, you will receive a statement in the mail and you will be responsible for the remaining account balance.

Thank you for choosing Aesthetic and General Dentistry for your Dental necessities. We look forward to a long lasting relationship with you.

I have read and understand the Insurance billing process at Aesthetic and General Dentistry.

Patient or/and Guarantor Signature: _____

Patient's Name: _____ Date: _____

Witness's Signature: _____ Date: _____

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Informed Consent for Photographs

I understand that photographs, x-rays, and other records may be made during the course of my examination, treatment, and follow-up care. I give permission for such items to be used for the purpose of research, education, or publication in professional journals.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

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