South Florida Dental Arts

Dr. Jorge O. Hernandez D.D.S. & Associates

6080 Bird Rd., Suite 8

Miami, FL 33155

Patient Registration

First Name:	Last Name:
Middle Name:	Preferred Name:

Person is which of the following? (Circle all that apply)

Patient	Yes	No
Policy Holder	Yes	No
Responsible Party	Yes	No

Address:

City:	State:	Zip Code:
Home Phone:	Work Phone:	Mobile Phone:
Date of Birth:	Social Security #	

Drivers License Number:

Email Address:

Emergency Contact Name:

Emergency Contact Phone Number:

Sex:				Male	Female
Marital Status:	Single	Married	Separated	Divorced	Widowed
Employment Status:			Full Time	Part Time	Unemployed
Student Status:			Full Time	Part Time	N/A

Responsible Party (If same as patient please leave blank)

Name:	Address:	
City:	State:	Zip Code:
Home Phone:	Work Phone:	Mobile Phone:
Date of Birth:	Social Security #	
Drivers License Number:		
Email Address:		

Primary Insurance Information

Name of Insured:	Insured Social Security #	
Insured Date of Birth:	Relationship to Insured:	
Employer:	Insurance Company:	
Insurance Company Address:		
City:	State:	Zip Code:
Remaining Benefits:	Remaining Deductable:	

Secondary Insurance Information

Name of Insured:	Insured Social Security #	
Insured Date of Birth:	Relationship to Insured:	
Employer:	Insurance Company:	
Insurance Company Address:		
City:	State:	Zip Code:
Remaining Benefits:	Remaining Deductable:	

How did you hear about us? (Circle all that apply)

Doctor that Referred You:			Patient that Referred You:		
Google	Yelp	Yahoo	Bing	Yellow Pages	Facebook
Instagram	Twitter	Newspaper	TV	Radio	Groupon
Sign	Flyer	Insurance	Employer	Walk In	Other

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. (Circle all that apply)

Are you under a physicians care now?	Yes	No
If Yes:		
Have you ever been hospitalized or had 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 other medication containing bisphosphonates?	Yes	No
If yes:		
Are you on a special diet?	Yes	No
Do you use tobacco?	Yes	No

Women are you one of the following?

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:			

Do you use controlled substances?	Yes	No

Do you have, or have you had any of the following? **(Circle all that apply)**

AIDS/HIV Positive	Yes	No	Excessive Thirst	Yes	No	Mitral Valve Prolapse	Yes	No
Alzheimer's Disease	Yes	No	Fainting Spells/ Dizziness	Yes	No	Osteoporosis	Yes	No
Anaphylaxis	Yes	No	Frequent Cough	Yes	No	Pain in Jaw Joints	Yes	No
Anemia	Yes	No	Frequent Diarrhea	Yes	No	Parathyroid Disease	Yes	No
Angina	Yes	No	Frequent Headaches	Yes	No	Psychiatric Care	Yes	No
Arthritis/ Gout	Yes	No	Genital Herpes	Yes	No	Radiation Treatments	Yes	No
Artificial Heart Valve	Yes	No	Glaucoma	Yes	No	Recent Weight Loss	Yes	No
Artificial Joint	Yes	No	Hay Fever	Yes	No	Renal Dialysis	Yes	No
Asthma	Yes	No	Heart Attack/Failure	Yes	No	Rheumatic Fever	Yes	No
Blood Disease	Yes	No	Heart Murmur	Yes	No	Rheumatism	Yes	No
Blood Transfusion	Yes	No	Heart Pacemaker	Yes	No	Scarlet Fever	Yes	No
Breathing Problems	Yes	No	Heart Trouble/Disease	Yes	No	Shingles	Yes	No
Bruise Easily	Yes	No	Hemophilia	Yes	No	Sickle Cell Disease	Yes	No
Cancer	Yes	No	Hepatitis A	Yes	No	Sinus Trouble	Yes	No
Chemotherapy	Yes	No	Hepatitis B or C	Yes	No	Spina Bifida	Yes	No
Chest Pains	Yes	No	Herpes	Yes	No	Stomach/Intestinal Disease	Yes	No
Cold Sores/Fever Blisters	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Congenital Heart Disorder	Yes	No	High Cholesterol	Yes	No	Swelling of Limbs	Yes	No
Convulsions	Yes	No	Hives or Rash	Yes	No	Thyroid Disease	Yes	No
Cortisone Medicine	Yes	No	Hypoglycemia	Yes	No	Tonsillitis	Yes	No
Diabetes	Yes	No	Irregular Heartbeat	Yes	No	Tuberculosis	Yes	No
Drug Addiction	Yes	No	Kidney Problems	Yes	No	Tumors or Growths	Yes	No
Easily Winded	Yes	No	Leukemia	Yes	No	Ulcers	Yes	No
Emphysema	Yes	No	Liver Disease	Yes	No	Venereal Disease	Yes	No
Epilepsy or Seizures	Yes	No	Low Blood Pressure	Yes	No	Yellow Jaundice	Yes	No
Excessive Bleeding	Yes	No	Lung Disease	Yes	No	Other:		

Comments:

How can we help you improve your smile?

Please Read and Sign Below

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, medical history, or medications.

Patient or Legal Representative (Print Name)	Patient or Legal Representative Signature	Date
Doctor (Print Name)	Doctor Signature	Date

Financial Arrangement and Treatment Plan Policy

Our Financial and Appointment Policies are designed to clearly explain our practice expectations from you, the patient, and our internal policies. This will eliminate any misunderstandings and will clearly establish everyone's responsibilities.

Appointment

There is a $25.00 fee for no show appointments, and a $10.00 fee on no shows due to emergencies. An emergency will be considered incidents such as an accident or an unforeseen medical emergency. We have allocated dental staff and other resources for your individual dental needs, which will result in a financial loss if you do not call us within 48 business hours before your appointment, so that we may effectively re-utilize the time with the doctor or hygienist.

Fees

Our office fees are based on usual and customary high quality community standards of dental care fee practices. We use the best dental materials, the most advance dental technology, and the latest dental techniques for diagnosing and treating our patients. We do not base our prices on dental insurance's fee schedules or HMO's standards. Prices and treatment plans are explained on your initial appointment; a treatment plan is presented for your acceptance and signature, and its acceptance represents a financial commitment on your behalf. At this time, you are expected to make payment arrangements with our office staff, dependant on office protocol.

Payments

Payment is expected in full the day services are rendered, and any permanent and removable dental appliances must be paid before delivery. Our office does not make payment plans. However, for your convenience, we provide you with several independent lending institutions' credit lending options, that our clerical staff will be happy to help you process the application. In addition, we accept cash, checks, and credit cards.

Insurance

Please remember that your dental benefits program is a contract between you and your dental insurance company, we expect you to pay any co-payments, deductibles, and patient portions (the portion of the bill that the insurance will not pay) at the time services are rendered, or make credit lending arrangements at the time you accept out treatment plan.

Return Checks

There will be a $25.00 fee assessed and charged to your account on any return checks.

Requests for X-Rays and Dental Records

There will be a $30.00 fee assessed for requested copies of x-rays and dental records. Requests for x-rays and dental records MUST be in writing and signed by the patient or legal guardian. We will have 30 days to comply with the request.

Collection Policy

Please be advised that any balances that remain unpaid after 30 days will be considered severely past due. If a balance is unpaid after 30 days, the account will be turned over for further collection action, to the appropriate collection agency. If an account is turned over to a collection agency and/or attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees that this office incurs while attempting to collect on the unpaid balance. These collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent Dr. Jorge O. Hernandez D.D.S. and associates may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Dr. Jorge O. Hernandez Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Dr. Jorge O. Hernandez D.D.S. and associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at [Dr. Jorge O. Hernandez D.D.S., 6080 SW 40th St. Suite 8, Miami, FL 33155, (305) 665-6564.

With my consent, Dr. Jorge O. Hernandez D.D.S. and associates may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dr. Jorge O. Hernandez D.D.S. and associates may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Dr. Jorge O. Hernandez D.D.S. and associates may e-mail to me or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements. I have the right to request that Dr. Jorge O. Hernandez D.D.S. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

By signing this form, I am consenting to Dr. Jorge O. Hernandez D.D.S. and associates to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, Dr. Jorge O. Hernandez D.D.S. and associates may decline to provide treatment to me.

Authorization to Send/Receive Email and Text Message Notifications

We now have the ability to email and/or text you, reminding you of your appointments and special offers related to our dental office. If you would like to receive this feature in the future, please read the consent below and sign. This consent to email and/or text message consists of, Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, receive special offers, and to provide general health information.

I consent to receiving appointment reminders and communications/information at the email and/or phone number I have provided, and any number forwarded or transferred to/from that phone number. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders and other healthcare communications.

Patient Consent to Medication Management and Prescribed Controlled Substances

All medications are associated with risks, harmful interactions and benefits. Whenever any medication is taken, you are accepting all the risks associated with the medication. These risks are included in the medication packet inserts.

The long-term use of controlled substances such as opiates (narcotic analgesics), benzodiazepine, and other sedatives are controversial because there are no proven long-term benefits associated with their use. What is certain is the risk of an addictive disorder (Psychological dependence/physical dependence) developing, as well as the risk of relapse occurring in a person with a prior addiction. Overdose of opiate medication may cause injury or death by stopping breathing.

I understand and accept that there may be unknown risks associated with the long-term use of substances prescribed. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).

Rx Prescription Refill Policies

- No prescriptions will be refilled on Saturdays, Sundays, or Holidays.
- Require 3 business days minimum to process Prescription(s) renewal and/or pick-up requests.
- The patient is responsible for knowing when medication(s) will need to be refilled (no early refills).
- Prescription phone in pick-up: Monday-Friday during business hours **ONLY** (9am-4pm).
- Prescriptions will not be filled for unauthorized “walk-in” patients.
- Non-controlled/non-narcotic prescriptions require a follow up appointment every **3-6 months**.
- Controlled-substances/non-narcotic prescriptions require a follow up appointment every **30-90 days**.
- New symptoms and/or events require a clinical appointment, provider is unable to diagnose via phone.
- Sign “Controlled-Substance Policy” required if using narcotic/controlled medications.
- No early refill if medications are overused/abused/misused, and must follow prescription directions.

- No medication/prescription will be replaced if lost, stolen, misplaced, overused, etc.
- Medications are for the prescribed individual's use only. It is illegal to "share" your medications.
- Patient must pick-up his/her Prescriptions in person, unless pre-authorized by staff.
- I will notify my treating and/or prescribing physician of any change in my medical condition, including pregnancy for females.
- I will take any and all prescribed medications only as directed by my physician or authorized associate. I will not obtain pain medications from more than one physician, request early refills, or request replacement of lost or stolen prescriptions.
- I will NOT request refills of medications and prescriptions after hours, on weekends, or on holidays.
- I will fully read the packet inserts of prescribed medications, in order to fully understand the risks and benefits of each prescribed medications, I will present any questions or concerns that may arise after reading the inserts to my physician.
- I will submit to random urine or blood prescription monitoring testing to ensure medications are utilized properly and prescribed, and that no illegal substances are present.
- I realize it is my responsibility to keep others and myself from harm, this includes the safety of my driving and the operation of machine. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed by Dr. Jorge O. Hernandez, D.D.S. and associates.
- I will not use any illegal substances (cocaine, heroin, marijuana, crystal meth, ecstasy, ketamine, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of care by Dr. Jorge O. Hernandez D.D.S. and associates effective immediately.
- I will not alter my medication in any way (for example crushing or chewing tablets) or use any other auto delivery (for example injection on insufflations) other than as prescribed by Dr. Jorge O. Hernandez D.D.S. and associates.
- I understand that changing date, quantity, strength of medications, or altering a prescription in any way, shape or form is against the law. Forging prescriptions or the provider's signature is against the law. We will fully cooperate with law enforcement agencies locally as well as the Drug Enforcement Agency (DEA) regarding any infractions involving prescription medications. Violation of the law will be reported to the patient's pharmacy, local authorities, and the DEA.
- I will discontinue all previously used pain medications, unless told to continue them by my prescribing physician. You the patient also agree to inform other treating physicians that you are under a controlled substance agreement.
- I agree to address any concerns or issues regarding my treatment with my physician or authorized associates.
- I agree to obtain my prescriptions from one pharmacy. The pharmacy I have selected is:

Pharmacy Name:	Pharmacy Number:

Location:

I understand that these protocols are per recommendations of the DEA, and any violation of the policies contained herein may result in my permanent and irreversible discharge from South Florida Dental Arts. I understand, accept and agree to the protocols and all items listed above. I understand that failure to comply will lead to immediate termination of all prescription medications.

Patient (Print Name)	Patient Signature	Date

Patient's Authorized Representative (If patient is under 18 years of age or you are consenting to the care of another)

I have the legal authority to sign this consent on behalf of:

Minor Patient's Name:

Your Relationship to Patient	Signature	Date

Administration (Print Name)	Administrative Signature	Date