Apex Dental

6330 Riverside Plaza Ln NW, Ste 165, Albuquerque, NM 87120

Patient Information

Date*: _____

Patient Name: _____ _____ _____
Last* First* MI

Gender: _____ Marital Status: ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Partnered ☐ Separated ☐ Minor

Social Security #: _____ Date of Birth*: _____

Parent or Legal Guardian Name: _____ _____ _____
(For Minor Patients) Last* First* MI

Relationship to Patient: ☐ Mom ☐ Dad ☐ Step Mother ☐ Step Father ☐ Other: _____
(For Minor Patients)

Phone (Home*): _____ Phone (Cell*): _____ (Work): _____ Ext: _____

Best time to call: _____AM/PM E-Mail*: _____

Address*: _____ _____
Street* Suite/Apartment*#

_____ _____ _____
City* State* Zip Code*

Person Responsible for Payment

Relationship to Patients*: ☐Father ☐Mother ☐Self ☐Spouse ☐Other: _____

Name*: _____ _____ _____
Last* First* MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home*): _____ (Work): _____ Ext: _____ Best time to call: _____

Address*: _____ _____
Street* Suite/ Apartment*#

_____ _____ _____
City* State* Zip Code*

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____
Phone: _____

Address: _____ _____ _____ _____
Street City State Zip Code

Insurance Information

Primary Insurance

Name of Primary Policy Holder: _____ Birth Date: _____
Last First MI

ID #: _____ Group #: _____Social Security#:_____

Address: _____
Street City State Zip Code

Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary Insurance

Name of Primary Policy Holder: _____ Birth Date: _____
Last First MI

ID #: _____ Group #: _____Social Security#:_____

Address: _____
Street City State Zip Code

Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Friends ☐ Relatives ☐ Neighbors

☐ Another Dental Office ☐ Postcard ☐ Online ☐ School ☐ Work ☐ Other: _____

Name of person or office referring you to our practice: _____

Consent for Services

All patients are required to bring at least one Government issued Photo Identification for their appointment.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

***I grant my permission to you or your assignee, to telephone me at ☐ home or ☐at my work to discuss matters related to this form and future appointments.**

EARLY AND EVENING APPOINTMENTS are available on a limited basis, please speak with patient coordinator to discuss availability. Patients are seen by appointments and walk in patients are attended to as soon as possible, dependent on schedule and availability. Emergency situations do not require appointments and will be attended to right away.

If for some reason you have made an appointment which you cannot keep, please notify us **at least** TWENTY FOUR **(24) HOURS prior** to the visit during our normal business hours. PLEASE MAKE SURE TO SPEAK PERSONALLY TO ONE OF OUR PATIENT COORDINATORS REGARDING ANY CHANGES. This courtesy allows us to make time available to other patients.

***ALL ORIGINAL SIGNATURES NEED TO BE DONE AT THE TIME OF APPOINTMENT MANUALLY. NO ELECTRONIC, PHOTO COPY OR FACIMAIL OF SIGNATURES PERMITTED ON THIS FORM.**

INSURANCE AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to APEX DENTAL LLC., 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 use of my signature on all insurance submissions. Dr. Dental may use my health care information and may disclose such information to the above-named Insurance Company('ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date*: _____Relationship to Patient*: _____
Signature of Patient or Guarantor of payment/responsible party

Health Information

NEEDS TO BE UPDATED IMMEDIATELY WHEN CHANGES IN HEALTH INFORMATION OCURR OR ATLEAST EVERY 6 MONTH, EVEN IF NO CHANGES ARE REPORTED

DENTAL HISTORY

Patient Name: _____ **DOB:** _____

Reason for Today's Visit*: _____

Date of last dental visit: _____ Former Dentist: _____

Address of Former Dentist: _____ Date of last dental x-rays: _____

Check if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Cavities
- ☐ Clicking or popping jaw
- ☐ Misaligned teeth
- ☐ Grinding teeth
- ☐ Loose teeth
- ☐ Broken Teeth
- ☐ Broken Fillings
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores/ Growths in your mouth
- ☐ Wisdom teeth pain
- ☐ How often do you floss? _____
- ☐ How often do you brush? _____

MEDICAL HISTORY

Office Use Only: Weight: _____ BP: _____ Pulse: _____

Have you ever had or do you have any of the following?

Yes	No	
☐	☐	Abnormal Bleeding*
☐	☐	Allergies*: _____
☐	☐	Allergy Codeine*
☐	☐	Allergy Latex*
☐	☐	Allergy Penicillin*
☐	☐	Allergy Sulfa Drugs*
☐	☐	Alzheimer 's Disease
☐	☐	Anaphylaxis
☐	☐	Anemia
☐	☐	Arthritis/Gout
☐	☐	Artificial Heart Valves*
☐	☐	Artificial Joints*
☐	☐	Asthma*
☐	☐	Bisphosphonates Use*
☐	☐	Blood Diseases*
☐	☐	Blood Thinners*
☐	☐	Blood Transfusion
☐	☐	Breathing Problems
☐	☐	Cancer*
☐	☐	Chemical Dependency*
☐	☐	Chemotherapy*
☐	☐	Chest pain/ Angina*
☐	☐	Cold Sores/Fever Blisters
☐	☐	Congenital Heart defects*
☐	☐	Convulsions
☐	☐	Cortisone Medicine
☐	☐	Diabetes*
☐	☐	Dialysis *
☐	☐	Drug Addiction
☐	☐	Emphysema
☐	☐	Endocarditis*
☐	☐	Epilepsy
☐	☐	Excessive Bleeding
☐	☐	Fainting
☐	☐	Frequent Cough
☐	☐	Frequent Headaches
☐	☐	Genital Herpes
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Head Injuries
☐	☐	Heart Attack/Failure
☐	☐	Heart Diseases*
☐	☐	Heart Murmur
☐	☐	Heart Pacemaker*
☐	☐	Hemophilia
☐	☐	Hepatitis* _____ **(A, B, C, D, E)**
☐	☐	Herpes
☐	☐	High Blood Pressure*
☐	☐	High Cholesterol
☐	☐	HIV / AIDS*
☐	☐	Hives/ Rash
☐	☐	Hypoglycemia
☐	☐	Irregular Heartbeat
☐	☐	Kidney Problems*
☐	☐	Leukemia
☐	☐	Liver problems*
☐	☐	Low Blood Pressure
☐	☐	Lung Disease*
☐	☐	Lupus (SLE)
☐	☐	Mental Disorders
☐	☐	Mitral Valve Prolapse
☐	☐	Organ Transplantation*
☐	☐	Osteoporosis
☐	☐	Medication Allergies* _____
☐	☐	Psychiatric Care
☐	☐	Radiation Treatment*
☐	☐	Renal Dialysis
☐	☐	Respiratory Problems*
☐	☐	Rheumatic Fever
☐	☐	Rheumatoid arthritis*
☐	☐	Scarlet Fever
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Spina Bifida
☐	☐	Spleen removed*
☐	☐	Stomach/Intestinal Disease
☐	☐	Stroke
☐	☐	Thyroid Problems*
☐	☐	Tobacco usage*
☐	☐	Tonsillitis
☐	☐	Tuberculosis*
☐	☐	Tumors or Growths
☐	☐	Ulcers
☐	☐	Venereal Diseases
		Women only
☐	☐	Pregnancy
☐	☐	Are you nursing
☐	☐	Talking Birth Control

- Have you ever had any complications following dental treatment*? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been ever hospitalized*? ☐ Yes ☐ No
  If yes when and what for? _____
- Do you wish to speak privately about anything*? ☐ Yes ☐ No
- Do you take any medications currently (including over-the counter drugs)*? ☐ Yes ☐ No
  _____
- Is there any condition concerning your health that the doctor should be told about* ☐ Yes ☐ No
  _____
- List any medication that you are Allergic or that make you sick:
  _____
- Are you now under the care of a physician*? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone: _____
  Last medical Appointment: _____
- Do you have any health problems that need further clarification*? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers including patient contact information and Health information provided are true and correct. If I ever have any change in my health, I will inform the dentist at the next appointment without fail.

_____ Date*: _____ _____

Full Name of patient or personal representative*
(Parent or Legal Guardian in case of minors)

Signature

Dentist Signature: _____

GENERAL CONSENT AND AUTHORIZATION

FOR DENTAL AND/OR MEDICAL SERVICES

We at Apex Dental appreciate the opportunity to serve you. It is our intent to provide you with the finest care possible while ensuring that you fully understand our procedures and treatment. To insure that your care comes first, we require your consent for Apex Dental to treat you under all circumstances while in this facility as follows:

The undersigned, on behalf of himself/herself, or minor (if applicable) hereby authorizes and consents to any reasonable Dental or Medical examination, X-ray examination, Anesthetics, Medical or Surgical diagnosis, Treatment and/or transport to hospital care (if deemed necessary) to be rendered by any of our Dentists, licensed in the State of New Mexico.

A parent or legal guardian or family member (Adults) or personal member with written consent must accompany all minors and special needs patients for treatment and remain in treatment or reception area so the minor's history and treatment plan can be discusses and any consent or exam forms signed if needed. Children who are not patients are not allowed in treatment area for safety and infection control reasons. If there is no one to watch your child your appointment will be rescheduled.

I HEREBY CONFIRM, CONSENT, AND AGREE TO THE FOREGOING.

Date*: _____

_____ _____ _____

Last* **First*** **MI***

Full Name of patient or personal representative (Parent or Legal Guardian in case of minors) *

Signature: _____ Relationship*: _____

(IF THE PATIENT IS A MINOR, A SIGNATURE OF THE PARENT OR LEGAL GUARDIAN IS REQUIRED)

ACKNOWLEDGEMENT OF RECIEPT OF HIPAA NOTICE OF PRIVACY PRACTICES

APEX DENTAL
6330 RIVERSIDE PLAZA LN NW, STE 165
ALBUQUERQUE, NM 87120

Acknowledgement

I, ______________________________, hereby acknowledge that I have received and reviewed a copy of APEX DENTAL's HIPAA *Notice of Privacy Practices.*
I understand that APEX DENTAL's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of APEX DENTAL's revised HIPAA *Notice of Privacy Practices* upon request.
I understand that, if I have question about APEX DENTAL'S *HIPAA Notice of Privacy Practices,* I may speak with Office Coordinator.
I understand that it is my right to refuse to sign this Acknowledgment should I so choose, and that Apex Dental will not refuse treatment to me if I refuse to sign this Acknowledgment.
I further understand that I may contact the Secretary of U. S. Department of Health and Human Services should I have concerns regarding APEX DENTAL's *HIPPA* privacy policies and privacy policies and procedures.

Request for confidential communications

*Written communications:

Address: ________________________________ ☐ Same Address as Listed on Patient Information Form

____

***Messages:**

Please call: [ ] my home [ ] my work [ ] my cell Number (Listed on Patient Information Form)
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] Other: ____

Release of Information

[ ] I authorize the release of information including the diagnosis, Treatment plan, appointments, records; examination rendered to me and claims information. This information may be released to:
[ ] Spouse______________________________________ [ ] Other_______________________________________

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Patient Signature: _____________________________ **Date:** __________

Or

Legal Guardian Signature**:** _________________________

FOR OFFICE USE ONLY *************************************

APEX DENTAL made a good- faith effort to obtain Acknowledgment, from the patient noted above, of receipt of its *HIPPA Notice of Privacy Practice's.* In spite of these efforts, APEX DENTAL was unable to obtain a signed Acknowledgment for the following reason(s):

- ☐ Refusal to sign Acknowledgment on ________________________, 20______
- ☐ Communication barriers prohibits us from obtaining a signed Acknowledgment.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgment.
- ☐ Other (Describe): ____.

6330 RIVERSIDE PLAZA LN NW, STE 165
ALBUQUERQUE, NM 87120
Phone : (505) 585-5157

LEGAL GUARDIAN AUTHORIZATION FORM

Patient's Name (*printed*):_____Date of Birth: _____

Legal Guardian Name (*printed*):_____

Relationship to Patient: ☐ Mom ☐ Dad ☐ Step Mother ☐ Step Father ☐ Other: _____

I authorize the following persons below to take my child to and from his/her appointments, and to make all necessary decisions to complete major and or minor procedures including (*please check all that apply*):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

- ☐ Schedule appointments
- ☐ Dental Cleaning that may include; Examination, Radiograph, Prophylaxis, Periodontal treatment & Fluoride treatment.
- ☐ Oral Surgery
- ☐ Basic and Minor Restorative treatment
- ☐ Go over financial information (co-payments, past due balance, account history)

OR

- ☐ **I DO NOT** authorize anyone else besides the guardians listed on the welcome new patient intake form to bring my child to his/her appointments

Legal Guardian Signature: _____ Date: _____