



Doris A. Ferres, DMD

COSMETIC AND GENERAL DENTISTRY

Patient Registration

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

Patient Is: Policy Holder

Preferred Name: _____

Responsible Party

Responsible Party (if someone other than the patient)

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

Address: _____

City, State, Zip: _____

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

Birth Date: _____ Social Security: _____ Drivers License: _____

Patient Information

Address: _____ Address 2: _____

City, State, Zip: _____

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

Birth Date: _____ Social Security: _____ Drivers License: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Employer ID: _____

Pref. Pharmacy: _____

Carrier ID: _____

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

ATTENTION PATIENTS:

"We ask that you realize that we do NOT work for an insurance company. Rather, we work 100 % for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge WILL ALWAYS BE BASED ON YOUR INDIVIDUAL NEEDS, NOT YOUR INSURANCE COVERAGE"

MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

IF YOU ANSWER YES TO ANY OF THE FOLLOWING, PLEASE EXPLAIN

Have you EVER been instructed to take antibiotics before dental treatment? YES NO

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any
Other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women:

Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs Other: _____

Do you have, or have you had, any of the following?

- | | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Herpes | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma Q Yes | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever 0 Yes | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | | | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No

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 _____

DATE: _____

OFFICE POLICIES

WE ASK THAT YOU GIVE A **48 HOUR NOTICE** FOR **ALL** APPOINTMENT CHANGES. THIS ALLOWS US TO UTILIZE YOUR SCHEDULED TIME TO TREAT PATIENTS WITH IMMEDIATE NEEDS.

FAILURE TO NOTIFY US WILL RESULT IN A \$60.00 MINIMUM CHARGE.

Initial:_____

IF YOUR INSURANCE BENEFITS CHANGE WE **REQUIRE A MINIMUM** OF 48 HOURS NOTICE! FAILURE TO DO SO WILL RESULT IN A GREATER OUT OF POCKET EXPENSE TO YOU.

Initial:_____

By signing I am confirming that I have read and understood, "Important Dental Insurance Information For Our Patients."

Signature of Patient/Parent/Guardian

Date

I hereby authorize Dr. Doris A. Ferres to release to my insurance company, information acquired in the course of my dental care.

I hereby authorize benefits to be paid directly to Dr. Doris A. Ferres.

Signature of Patient/Parent/Guardian

Date

I understand that I am responsible for any unpaid balance.

Signature of Patient/Parent/Guardian

Date

Due to increased cost we will no longer send statements or reimbursement checks for balances of \$5.00 or less.

PHOTOGRAPHIC RELEASE AND CONSENT FORM

I hereby grant to DR. DORIS FERRES, DMD, PA and its representatives the irrevocable and unrestricted right to reproduce and display photographs and videos of me and/or my teeth in print, on the office's website or any other lawful purpose for advertising. I release to **Dr. Doris Ferres and its employees and legal representatives** from any and all claims, actions and liability relating to its use of said photographs and videos.

Signature: _____ Date: _____

MINORS ONLY: If signature above is by a person under the age of 21, parent or guardian should sign below: The parent or guardian, hereby consent to the foregoing.

Signature: _____ Date: _____



Doris Ferres DMD

4125 9th St SW Vero Beach, FL 32968

Tel- (772) 567-1011 Fax: (772) 567-1170

Consent to Receive Text Messages

By signing below, I authorize Doris Ferres DMD to contact me by SMS text message for health related notifications. Later phases may include appointment reminders.

I understand that message/data rates may apply to messages sent by Doris Ferres DMD under my cell phone plan.

I know that I am under no obligation to authorize Doris Ferres DMD to send me text messages. I may opt-out of receiving these communications at any time by calling the main line (772) 567-1011 and speaking with a representative.

I understand that text messages are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

Name: _____

Signature: _____

Date: _____

Date of Birth: _____

Yes, sign me up for SMS text messages!

No, I choose not to participate in SMS text messages.



Doris Ferres DMD

4125 9 St SW Vero Beach, FL 32968

Tel- (772) 567-1011

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

Patient Name:_____ Signature:_____ Date:_____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Doris A. Ferres, DMD, PA. may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Doris A. Ferres, DMD, PA has a detailed document called the 'Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Doris A. Ferres, DMD, PA will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Doris A. Ferres, DMD, PA to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Doris A. Ferres, DMD, PA has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____
Date

Relationship to Patient if signed by another party _____
Date

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: **Daisy Mallen, MBA. Privacy Officer.**

4125 9th Street SW, Vero Beach, Florida 32968. Phone: (772) 567-1011.