Doris A. Ferres, DMD

COSMETIC AND GENERAL DENTISTRY

Patient Registration

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

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:_____

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:_____

Address:_____

Address 2:_____

City,State,Zip:_____

Ins. Company: _____

Address:_____

Address 2:_____

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 YOU 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 ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma Q Yes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever 0 Yes ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ 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
2980 9th Street SW Ste #102
Vero Beach, FL 32968
(772) 567-1011/(772) 567-1170 Fax

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.

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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.

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