Welcome To Springville Family Dental

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT INFORMATION

Today's date ____________ E-Mail Address: ____________

Name:

First ____________ Mi ____________ last ____________

I prefer to be called: ____________

__Male __Female Birthdate ___/___/___ Age: ____ SS#: ____________

Home Address: ____________

City: ____________ State ____ Zip ____________

____Single ____Married ____Divorced ____Widowed ____Separated

Home #: ____________ Work# ____________ Cell # ____________

EMPLOYER: ____________ Wk# ____________

Employer address ____________

How long there? ______ Occupation: ____________

Whom may we thank for referring you? ____________

Other family members seen by us? ____________

Previous/Present Dentist: ____________ Date of last visit: ______

SPOUSE INFORMATION

His/Her Name: first ____________ mi ____________ last ____________

Employer: ____________

Work # ____________ Birth date ___/___/___ DL# ____________

PERSON RESPONSIBLE FOR ACCOUNT:

Name: ____________ Birth date ______ Relationship to patient: ______

SS#: ____________ Employer: ____________

PRIMARY INSURANCE

Dental Insurance company : ____________

Address: ____________ Phone # ____________

Group # ____________ Contract/Policy # ____________

Insured's Names: ____________ Insured's birthdate ___/___/___

Relation to patient: ____________ Insured's employer: ____________

SECONDARY INSURANCE

Dental Insurance company ____________

Address: ____________ Phone# ____________

Group # ____________ Contract/Policy # ____________

Insured's Names: ____________ Insured's birthdate ___/___/___

Relation to patient: ____________ Insured's employer: ____________

Neighbor or Relative not living with you:

Name: ____________ Relation: ____________ Contact # ____________

DENTAL HISTORY

Reason for today's visit

____

Former Dentist_________________________Address _______________________

Date of last visit _______________Date of last dental X-rays _____________

Do you have or ever had any of the follow:

___Bad Breath ___ Bleeding Gums ___Clicking or Popping Jaws

___ Food collection Between the teeth ___ Grinding Teeth ___ Sensitivity to sweets

___ Loose teeth or broken fillings ___ Periodontal treatment ___ Sensitivity to cold

___ Sensitivity to Heat ___ Sensitivity when biting ___ Sores or growths in your mouth

How often do you floss? __________________ How often do you brush? __________

MEDICAL HISTORY

Physician's Name _________________________ Date of last visit ___________

Have you had any serious illnesses or operations? __Yes __No If yes describe______

____

Have you ever had a blood transfusion? __Yes __No. If yes, give approximate date _____

Are you Pregnant or Nursing? ___Yes ___No Taking birth control pills ___ Yes ___ No

Check if you have had any of the following

___ Aids
___ Anemia
___ Arthritis Rheumatism
___ Artificial Heart Valves
___ Artificial Joints
___ Asthma
___ Back Problems
___ Blood Disease
___ Cancer
___ Chemical Dependency
___ Circulatory Problems
___ Cortisone Treatments
___ Cough Persistent
___ Diabetes
___ Epilepsy
___ Fainting
___ Glaucoma
___ Headaches
___ Heart Murmur
___ Heart Problems
Describe ______________
___ Hemophilia
___ Hepatitis
___ High Blood Pressure
___ HIV positive
___ Jaw pain
___ Kidney Disease
___ Liver Disease
___ Mitral Valve Prolapse
___ Nervous Problems
___ Pacemaker
___ Psychiatric Care
___ Radiation Treatment
___ Respiratory Disease
___ Rheumatic Fever
___ Scarlet Fever
___ Shortness of Breath
___ Skin Rash
___Stroke
___ Swelling of Feet/Ankles
___ Thyroid Problems
___ Tobacco Habit
___ Tonsillitis
___ Tuberculosis
___ Ulcer
___ Venereal Disease

List any medications You are currently taking

____

____

Are You allergic to any of the following?

__Aspirin ___Codeine ___ Dental Anesthetics ___ Erythromycin ___Tetracycline ___ Latex

__ Penicillin __ Other Please list any other drug/materials that you are allergic to: ____

____

Authorization & Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the Dr. Ronderos. I authorize the Dr. Ronderos to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

______________________________ ______________

Signature of patient or parent if minor Date

____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____day of ____________, 20 ___.

Print Patient Name: ____________________________

Relationship to Patient: __________________________

Signature: _____________________________________

Practice Name: Joseph V. Ronderos, DMD
P O Box 706
420 Walker Drive
Springville, Al 35146
(205) 467-6147

Joseph V. Ronderos, D.M.D.
420 Walker drive
P. O. Box 706

Fees and Payments: We make every effort to keep down the cost of your dental care. You can help by paying at the time of your visit. If your treatment program requires several visits, you will be given an estimate and asked to discuss definite financial arrangements with the financial manager.

We will be happy to file your insurance for you. We will file no more than the primary and secondary insurance. If you are covered by an additional insurance, we will be glad to furnish you the necessary forms to file on your own.

Please remember that no insurance company attempts to cover all dental cost. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company.

If any account is not paid in full by (60) days, service charge of 1 ½ % will be charged to the unpaid balance per month.

If your account has been turned over to a collection agency for collection, you are responsible for all cost of collection including a reasonable attorney fee.

We know questions regarding insurance may arise and we encourage you to discuss such matters with the insurance coordinator. We will be happy to help you receive the maximum benefits however, the arrangement of the insurance company to pay for your dental care is a contract between you and the company.

If you have questions, we will be glad to discuss the matter with you. Please sign below stating that you do understand the financial policy.

________________________________ ________________

Responsible Party / Patient Date