HSM Dental Group
Dr. Halina Montano, DDS
900 Glades Road, Ste. 1D, Boca Raton, FL 33431
(561) 232-2070

# PATIENT INFORMATION

## PERSONAL INFORMATION

Last Name ______________ First Name ______________ Middle Initial ______

Date of Birth ____/____/________ Social Security Number ______-_____-______ Gender (circle one): Male Female Married? (circle one): YES NO

Cell Phone Number (__________) __________-__________ Cell Phone Carrier ______________

Home Phone Number (__________) __________-__________ Work Phone Number (__________) __________-__________

Email Address ______________________

Street Address ______________ Apt./Ste. ______ City ______________ State ______ Zip Code ______

## INSURANCE INFORMATION (Please present your insurance card to the receptionist)

If you do not have dental insurance and will be considered a self-pay patient, please initial here: ______________

POLICY #1

Your relationship to the below subscriber (circle one): SELF SPOUSE CHILD

Subscriber's Last Name ______________ Subscriber's First Name ______________ Subscriber's ID Number ______________

Insurance Carrier ______________ Insurance Carrier's Phone Number (__________) __________-__________

Employer ______________ Group Name ______________ Group Number ______________

POLICY #2 (If Applicable)

Your relationship to the below subscriber (circle one): SELF SPOUSE CHILD

Subscriber's Last Name ______________ Subscriber's First Name ______________ Subscriber's ID Number ______________

Insurance Carrier ______________ Insurance Carrier's Phone Number (__________) __________-__________

Employer ______________ Group Name ______________ Group Number ______________

## PREFERRED CONTACT METHODS (circle one for each of the below)

| | | | | |
|---|---|---|---|---|
| General Correspondence: | Home Phone | Work Phone | Cell Phone | Email |
| Confirmations: | Home Phone | Work Phone | Cell Phone | Email |
| Recall: | Home Phone | Work Phone | Cell Phone | Email |

## FOR STUDENTS/DEPENDENTS OVER 19 YEARS OF AGE ONLY (circle only one below)

Student Status: Non-Student Full Time Student Part Time Student

How did you hear about us? ______________________________

If someone referred you to our practice, please provide their name above.

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# PATIENT MEDICAL HISTORY

## PERSONAL INFORMATION

_________________________ _________________________ __________

Last Name First Name Middle Initial

_____/_____/__________ _______-______-______ Male Female

Date of Birth Social Security Number Gender (circle one)

## EMERGENCY CONTACT INFORMATION

____________________ ____________________ ____________________

Last Name First Name Relationship to Patient

(____________) ____________-____________ (____________) ____________-____________

Home Phone Number Cell Phone Number

## MEDICATIONS Please list all medications you are currently taking. Include any over the counter medications & diet supplements.

| Drug | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## ALLERGIES (Please circle either YES or NO for each of the following)

| | | | | | |
|---|---|---|---|---|---|
| Anethetic | YES | NO | Iodine | YES | NO |
| Aspirin | YES | NO | Latex | YES | NO |
| Codeine | YES | NO | Penicillin | YES | NO |
| Ibuprofen | YES | NO | Sulfa | YES | NO |

## MEDICAL CONDITIONS (Please circle either YES or NO for each of the following)

| | | | | | |
|---|---|---|---|---|---|
| Asthma | YES | NO | Kidney Disease | YES | NO |
| Bleeding Problems | YES | NO | Liver Disease | YES | NO |
| Cancer | YES | NO | Pregnancy | YES | NO |
| Diabetes | YES | NO | Psychiatric Treatment | YES | NO |
| Heart Murmur | YES | NO | Sinus Trouble | YES | NO |
| Heart Trouble | YES | NO | Stroke | YES | NO |
| High Blood Pressure | YES | NO | Ulcers | YES | NO |
| Joint Replacement | YES | NO | Rheumatic Fever | YES | NO |

Do you use tobacco? YES NO If yes, what kind and how often? ______________________________

Do you have unusual reactions to dental injections? YES NO If yes, what kind? ____________________

Reason for today's visit: ______________________________ Are you experiencing pain? YES NO

Do you have a panoramic x-rays or full mouth x-rays that is less than 5 years old? YES NO

Do you have bitewing x-rays that are less than 1 year old? YES NO

Date of Last Exam/Cleaning: _____/_____/__________

______________________________ ____________________ __________

Name of Former Dentist City State

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# FINANCIAL AGREEMENT

________________________________ ________________________________ _____________
Last Name First Name Middle Initial

_____/_____/__________ (____________) ____________-____________
Date of Birth Phone Number

I, ______________________________________ hereby accept complete responsibility to pay the full balance due for all services rendered regardless of whether any dental insurance covers any portion of the balance due.

If I am covered by dental insurance I understand that I will be provided with an itemized list of the fees I am directly responsible for and will provide payment in full for that balance prior to any services being rendered. I understand that estimated insurance benefits (including pre-authorizations) are provided to me by HSM Dental Group based on the information I, along with my insurance provider, provide to them. ESTIMATED BENEFITS ARE NEVER GUARANTEED. With this understood, I agree to pay the full balance of any insurance claim not paid within sixty (60) days following the insurance claim filing. I understand that HSM Dental Group submits claims only to my primary dental insurance provider and is not responsible for any claim that is not paid by the insurance provider. I agree to pay a service charge in the amount of one and one half percent (1.5%) per month, equating to eighteen percent (18%) per annum on any past due balance plus all costs of collection efforts incurred by HSM Dental Group. Stated fees are valid for thirty (30) days and are subject to change prior to services being rendered due to changes in my insurance and to correct errors.

To assure convenient appointment availability, I understand that HSM Dental Group requires a ten percent (10%) deposit of the total fees due for the services to be rendered at the time of scheduling.

I hereby certify that I have read the above FINANCIAL AGREEMENT, understand my obligations, and agree to the above terms.

_____________________________________________ _____/_____/__________
Patient Signature or Signature of Patient Guardian Date

_____________________________________________
Printed Name

_____________________________________________
Printed Patient Name if Guardian Has Signed This Form

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# CONSENT FOR TREATMENT

| ______________________________ | ______________________________ | ____________ |
|---|---|---|
| Last Name | First Name | Middle Initial |

_____/_____/__________
Date of Birth

(____________) ____________-____________
Phone Number

This consent services as permission to for HSM Dental Group to treat the above named patient for all dental services. Please note that some insurance providers will only cover amalgam fillings. We do not use this type of material in our practice and therefore you will be solely responsible for a material upgrade and any additional charges that may be incurred.

I hereby certify that I have read the above CONSENT FOR TREATMENT, understand my obligations, and agree to the above terms.

__________________________________________
Patient Signature or Signature of Patient Guardian

_____/_____/__________
Date

__________________________________________
Printed Name

__________________________________________
Printed Patient Name <u>if</u> Guardian Has Signed This Form

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# NOTICE OF PRIVACY POLICY

__________________________________ __________________________________ _____________
Last Name First Name Middle Initial

_____/_____/__________ (_____________) _____________-_____________
Date of Birth Phone Number

HSM Dental Group has provided me access to read and consider the contents of the Notice of Privacy Practices. I full understand that I am giving my permission for HSM Dental Group to utilize my protected health information in order to provide treatment, render services, execute payment activities, and healthcare operations.

I hereby certify that I have read the above NOTICE OF PRIVACY POLICY and agree to the above terms.

_______________________________________________ _____/_____/__________
Patient Signature or Signature of Patient Guardian Date

_______________________________________________
Printed Name

_______________________________________________
Printed Patient Name <u>if</u> Guardian Has Signed This Form