DentalClinique
FAMILY DENTISTRY

PATIENT INFORMATION/ INFORMACION DEL PACIENTE

First Name/*Nombre* **Last Name/***Apellido*

Address/*Dirección*

City/*Ciudad* **State/***Estado* **Zip/***Código Postal*

Home Phone Number/*Tel de Casa* **Work Phone Number/***Tel Laboral*

Cel Phone Number/*Número Celular* **E-mail/***Correo Electrónico*

 # Social Security/*# de Seguro Social* **Date of Birth/***Fecha de Nacimiento*

Emergency Contact Name/*Nombre del contacto de emergencia* **Phone Number/***Tel*

INSURANCE CO

FEE SCHEDULE

POLICY HOLDER/INFORMATION DEL TITULAR DE LA POLIZA

Name/*Nombre* **Relationship to Patient/***Relación Paciente*

Address/*Dirección*

DentalClinique

City/*Ciudad* **State/***Estado* **Zip/***Código Postal*

 # Social Security/*# de Seguro Social* **Date of Birth/***Fecha de Nacimiento*

Employer Name/*Empleador* **Insurance company/***Empresa de Seguro*

Referred by/*Usted fue referido por* **Insurance company/***Empresa de Seguro*

Tel:(954) 228 6661 Fax: (954) 206 2838
16636 Sheridan St., Pembroke Pines Fl. 33331
email: drsegrera@dentalcliniquepines.com - www.dentalcliniquepines.com

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Dental History / *Antecedentes Dentales*

Y/S ____ N/N ____ **Are you experiencing any discomfort?** / *Siente alguna molestia?*

Y/S ____ N/N ____ **Do you have bleeding gums?** / *Le sangran las encías?*

Y/S ____ N/N ____ **Do you have bad breath?** / *Tiene mal aliento?*

Y/S ____ N/N ____ **Do you grind you teeth?** / *Aprieta los dientes?*

Y/S ____ N/N ____ **Are you sensitive to hot, cold or sweet?** / *Tiene sensibilidad al calor, frio o a lo dulce*

Y/S ____ N/N ____ **Have you ever received Periodontal therapy?** / *Ha recibido terapia periodontal alguna vez?*

Y/S ____ N/N ____ **Do you take a fluoride supplement?** / *Toma suplemento de fluor?*

Y/S ____ N/N ____ **Do you use tobacco?** / *Consume tabaco?*

Y/S ____ N/N ____ **Do you drink coffee?** / *Bebe cafe o te?*

Y/S ____ N/N ____ **Do you have difficulty brushing your teeth?** / *Tiene dificultad para cepillarse los dientes?*

________ **How would you rate your smile on a scale from 1 to 10 being the highest?** / *Como calificaría su sonrisa en una escala de 1 al 10 siendo 10 la clasificación mas alta?*

Dentures/Partial Patients/*Pacientes con Prótesis Parciales/Dentaduras*

Y/S ____ N/N ____ **Do you wear a denture or partial?** / *Usa dentadura postiza o prótesis parciales?*

Y/S ____ N/N ____ **Does your dentures cause irritation?**/ *Su dentadura le causa alguna irritación o dolor?*

Y/S ____ N/N ____ **Are your dentures loose?** / *Su dentadura postiza esta floja?*

________ **How old is your denture or partial?**/ *Que antiguedad tiene su dentadura postiza o partial?*

Medical History/*Antecedentes Medicos*

Primary Care Physician Name/*Medico de atención primaria* ________ **Phone #**/*Tel del medico* ________

Y/S ____ N/N ____ **Are you under a physician's care?** / *Se atiende con algún medico?*

Y/S ____ N/N ____ **Have you ever been hospitalized or has a major operation?** / *Alguna vez ha sido hospitalizado o ha sido sometido a una intervention quirúrgica importante?*

Y/S ____ N/N ____ **Have you ever had a serious head or neck injury?** / *Ha sufrido alguna vez una lesion de cabeza o cuello grave?*

Y/S ____ N/N ____ **Women: Are you pregnant?** / *Mujeres: Esta embarazada?*

Y/S ____ N/N ____ **Do you use controlled substances?** / *Utiliza sustancias de consumo controlado?*

If you answered YES to any of the above questions, please explain / *Si respondió Si a cualquiera de las preguntas, por favor explique?*

____

____

____

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Are you allergic or do you react adversely to any of the following? / *Es usted alérgico algunos de los siguientes elementos?*

Y/S ____ N/N ____ **Aspirin**/*Aspirina*
Y/S ____ N/N ____ **Metal**/*Metal*
Y/S ____ N/N ____ **Sulfa drugs**/*Fármacos con sulfa*
Y/S ____ N/N ____ **Milk protein**/*Proteína de la leche*
Y/S ____ N/N ____ **Barbiturates, sedatives or sleeping pills** *Barbitúricos, sedantes o pildoras para dormir.*
Y/S ____ N/N ____ **Local anesthetics (Novacaine-like medication)** *Anestésicos locales*
Y/S ____ N/N ____ **Acrylic**/*Acrilico*
Y/S ____ N/N ____ **Latex**/*Latex*
Y/S ____ N/N ____ **Codeine**/*Codeina*
Y/S ____ N/N ____ **Tetracycline**/*Tetraciclina*
Y/S ____ N/N ____ **Penicillin or other antibiotics**/ *Penicilina u otros antibióticos*

Other/*Otros*: ____________________

Please check any conditions that you currently or previously have had / *Marque las condiciones que tenga actualmente o que haya tenido anteriormente:*

- **AIDS/HIV Positive**/*SIDA Positivo*
- **Alzheimer's Disease**/*Enfermedad de Alzheimer*
- **Anaphylaxis**/*Anafilaxis*
- **Anemia**/*Anemia*
- **Arthitis/Gout/***Artritis/Gota*
- **Angina**/*Angina*
- **Artificial Heart Valve**/*Válvula cardiaca artificial*
- **Artificial Joint**/*Articulación artificial*
- **Asthma**/*Asma*
- **Blood Disease**/*Enfermedad Sanguínea*
- **Breathing Problem**/*Problemas respiratorios*
- **Bruise Easily**/*Formación de moretones*
- **Cancer**/*Cancer*
- **Chemotherapy**/*Quimioterapia*
- **Chest Pain**/*Dolores en el pecho*
- **Cold Sores**/*Fever Blisters / Aftas-ampollas*
- **Congenital Heart Disorder**/*Trastorno congénito*
- **Convulsions**/*Convulsiones*
- **Cortisone Medicine**/*Cortisona*
- **Diabetes**/*Diabetis*
- **Drugs Addiction**/*Drogadicción*
- **Easily Winded**/*Se agita facilmente*
- **Emphysema**/*Enfisema*
- **Endocarditis**/*Endocarditis*
- **Epilepsy or Seizures**/*Epilepsia o convulsiones*
- **Excessive Thirst**/*Sed excesiva*
- **Excessive Bleeding**/*Hemorragia excesiva*
- **Fainting Spells**/Episodios de *desmayos*
- **Frequent Cough**/*Tos frecuente*
- **Frequent Headaches**/*Dolores de cabeza*
- **Frequent diarrhea**/*Diarrea frecuente*
- **Glaucoma**/*Glaucoma*
- **Hay Faver**/*Fiebre del heno*
- **Heart Attack**/*Ataque cardiaco*
- **Heart Murmur**/*Soplo cardiaco*
- **Heart Pacemaker**/*Marcapasos cardiaco*
- **Heart Trouble/Disease**/*Problemas cardiacos*
- **Hemophilia**/*Hemofilia*
- **Hepatitis A**/*Hepatitis A*
- **Hepatitis B or C**/*Hepatitis B or C*
- **Herpes**/*Herpes*
- **High Blood Pressure**/*Presión alta*
- **Hiver or Rash**/*Erupciones*
- **Hypoglycemia**/*Hipoglicemia*
- **Irregular Heartbeat**/ *Frecuencia cardiaca irregular*
- **Kidney Problems/Problemas Renales**
- **Leukemia**/*Leucemia*
- **Liver Disease**/*Enfermedad Hepática*
- **Low Blood Pressue/Presión arterial baja**
- **Lung Disease**/*Enfermedad Pulmonar*
- **Mitral Valve Prolapse**/ *Prolapso de válvula mitral*
- ***Osteoporosis***/Osteoporosis
- **Pain Jaw Joints**/*Dolores en las articulaciones*
- **Parathyroid Disease**/*Enfermedad Paratiroides*
- **Parkinson's Disease**/*Enfermedad de Parkinson*
- **Pins, rodsor stints**/*Pernos, varillas, soportes*
- **Psychiatric Care**/*Atencion Psiquiátrica*
- **Radiation Treatments**/*Radioterapia*
- **Recent Weight Loss**/*Perdida de peso reciente*
- **Renal Dialysis**/*Diallsis Renal*
- **Rheumatic Fever**/*Fiebre Reumatica*
- **Rheumatism**/*Reumatismo*
- **Scarlet Fever**/*Escarlatina*
- **Shingles**/*Culebrilla*
- **Sickle Cell Disease**/*Celulas Falcimormes*
- **Sinus problem**/*Problemas en los senos para nasales*
- **Spina Bifida**/*Espina Bifida*
- **Stomach/intestinal Disease**/*Enfermedad estomacal*
- **Stroke**/*Accidente cerebrovascular*
- **Swelling of Limbs**/*Hinchazon de as extremidades*
- **Thyroid Disease**/*Enfermedad tiroidea*
- **Tonsillitis**/*Amigdalitis*
- **Tuberculosis**/*Tuberculosis*
- **Tumors or growths**/*Tumores o crecimientos*
- Ulcers/*Ulceras*
- **Venereal Disease**/*Enfermedad Venerea*
- **Yellow Jaundice**/*Ictericia*
- **None**/*Ninguno*

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Patient Signature / *Firma del Paciente* ____________________ **Date** / *Fecha* ____________________

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List any major diseases not listed before / *Mencione cualquier enfermedad importante que no se haya descrito anteriormente:*

Please check any medications or supplements taken in the past 12 months/
Marque los medicamentos o suplementos que haya tornado en los ultimos 12 meses:

- **Antibiotics or sulfa drugs**/ *Antibióticos o fármacos con sulfa*
- **Tranquilizer**/*Tranquilizantes*
- **Insulin or diabetes medication/** *Insulina o medicamentos diabetes*
- **Herbal Supplements**/*Suplementos a base de hierbas*
- **High blood pressure medicine**/ *Medicina para la presión alta*
- **Heart medications**/*Medicamentos para el Corazón*
- **Nitroglycerine**/*Nitroglicerina*
- **Anticoagulants(Coumadin, blood thinners)** *Anticoagulantes(coumadin)*
- **Contraceptives**/*Píldoras anticonceptivas*
- **Bisphosphonates (used to treat osteoporosis such as Fosamax, Boniva, Actonel and Zometa)/** *Bifosfonatos(usados para tartar la osteoporosis como Foxamax, Boniva, Actonel y Zometa*
- **Aspirin (daily)**/*Aspirina (diariamente)*

List all medications/supplements you are currently taking / *Mencione todos los medicamentos Suplementos que este tomando actualmente:*

I have answered all questions to the best of my knowledge. I will notify the dental health provider of any change in my health or medication each visit. I authorize the dentist/hygienist to use the necessary local/topical anesthesia to perform my treatment in a safe effective way during this visit and any future visits. i understand that my failure to provide information on previous adverse reactions may cause for negative reactions.
I release **DENTAL CLINIQUE** of all liability regarding undisclosed medial history information.

He respondido todas las preguntas de la mejor manera posible. Avisare al profesional dental en caso de cualquier cambio en mi salud o medicamentos en cada visita. Autorizo al dentista/higienista a usar el anestésico local/tópico necesario para realizar ml tratamiento de forma segura y efectiva durante esta visita y en visitas futuras. Entiendo que si no proporciono informacion sobre reacciones adversas anteriores es posible que se provoque, reacciones negativas inesperadas.
Libero a ***DENTAL CLINIQUE*** *de cualquier responsabilidad sobre la información de antecedentes medicos que no haya mencionado.*

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Signature of patient or Guardian/*Firma del paciente o tutor* **Date**/*Fecha*

If authorized guardian, relationship to patient / *Si es el tutor autorizado, la relación con el paciente*

Dentist Signature / *Firma del dentista.* **Date**/*Fecha*

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with **DENTAL CLINIQUE** "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

*Confirmo que se me ha provisto la "Notificación De Practicas De Privacidad" de **DENTAL CLINIQUE** y doy mi consentimiento para usar y divulgar información Personal De Salud como lo permita y/o requiera la ley.*

____

Patient Name (please print) / *Nombre Del Paciente: (nombre en letra de molde por favor)*

____

Patient Signature (or legal representative; proof may be requested) / *Firma Del Paciente (o representante legal; prueba puede ser requerida)*

____

Date / *Fecha:*

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **DENTAL CLINIQUE** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **DENTAL CLINIQUE** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **DENTAL CLINIQUE** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **DENTAL CLINIQUE** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

*Propósito: Esta forma es usada como consentimiento de usted para comunicarnos via correo electrónico/mensaje de texto a móvil en referencia a su información de Salud Protegida. **DENTAL CLINIQUE** ofrece a sus pacientes la oportunidad de comunicación via correo electrónico/mensaje de texto a móvil. Trasmitir información via correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **DENTAL CLINIQUE** usara formas razonables de proteger la confidencialidad y seguridad de la información enviada a usted via correo electrónico/mensaje de texto a móvil. De todas formas, **DENTAL CLINIQUE** no podrá garantizarle proteger la confidencialidad y la seguridad de la comunicación via correo electrónico/mensaje de texto a móvil y no sera en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.*

*Yo comprendo haber leído el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación via correo electrónico/mensaje de texto a móvil entre **DENTAL CLINIQUE** y yo consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me ha sido respondida.*

Patient Acknowledgement & Agreement / *Reconocimiento Acuerdo del Paciente*

____

My Email Address is / *Mi Correo Electrónico es*

____

My Text Messaging to # is / *Mi # de Mensaje de Texto es*

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FAMILY DENTISTRY

FINANCIAL INFORMATION

REGARDING INSURANCE
It is our pleasure to accept patients who have dental insurance. Our office will be happy to file your insurance forms for you at no charge as a courtesy. However we do require your deductible and co-payment (usually 20%-50%) to be paid at the time of service. We can not bill your insurance company unless you give us your insurance information. You hereby authorize insurance claim reimbursement of dental benefits to be paid directly to **DENTAL CLINIQUE**. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract, if your insurance company has not paid your account in full within 60 days or if you have received payment from insurance company the balance will be automatically due and payable by you.

OUR FEES
We treat every patient with equal care with or without insurance. Unfortunately, some insurance companies do not always cover certain established, routine and accepted procedures. We feel you deserve the best treatment possible and should not be influenced by the insurance company's policy. Since we do not have access to each plan's contract, it is difficult for us to know every limitation, deductible, or allowance for every procedure, it is important to know your policy's coverage.

Our practice is committed to providing the best treatment for our patients and we charge what is customary and reasonable for our area. You are responsible for payments regardless of any insurance company's arbitrary determination for usual and customary rates.
Patients without insurance are expected to pay when service are rendered.

We do not overbook our schedule. We believe in the importance of providing our patients with our complete attention. Therefore, you are responsible for **$ 50.00** charge for appointment not cancelled with a 24 hours notice. If you are over 20 minutes late for your appointment we will need to re-schedule.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy

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____
Signature of responsible party

____
Witness

____
Date

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FAMILY DENTISTRY

PATIENT CONSENT TO USE OF SURVEILLANCE CAMERAS

THIS DOCUMENT (THE AGREEMENT) CONTAINS IMPORTANT INFORMATION ABOUT OUR PROFESSIONAL SERVICES AND BUSINESS POLICIES AT DENTAL CLINIQUE IT ALSO CONTAINS SUMMARY INFORMATION ABOUT THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), A FEDERAL LAW THAT PROVIDES PRIVACY PROTECTIONS AND PATIENT RIGHTS WITH REGARD TO THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI) USED FOR THE PURPOSE OF HEALTH CARE OPERATIONS. HIPAA REQUIRES THAT WE PROVIDE YOU WITH A NOTICE OF PRIVACY PRACTICES (THE NOTICE) FOR USE AND DISCLOSURE OF PHI FOR HEALTH CARE OPERATIONS. WHEN YOU SIGN THIS DOCUMENT, IT WILL ALSO REPRESENT AN AGREEMENT BETWEEN YOU AND DENTAL CLINIQUE. YOU MAY REVOKE THIS AGREEMENT IN WRITING AT ANY TIME.

DENTAL CLINIQUE USES SURVEILLANCE VIDEO CAMERAS IN ITS COMMON AREAS, INCLUDING BUT NOT LIMITED TO THE EXTERIOR OF THE BUILDING, WAITING ROOM, RECEPTIONS AREA, HALL WAYS, OPERATORIES AND X-RAY AREAS. SURVEILLANCE EQUIPMENT WILL NEVER BE USED IN PRIVATE SPACES, SUCH AS RESTROOMS OR DOCTORS' OFFICES. THE CAMERAS RUN CONTINUOUSLY, 24 HOURS PER DAY, SEVEN DAYS A WEEK. THE DVR DEVICE THAT RECORDS THE VIDEO IS ONLY ACCESSIBLE BY THE OWNERS OF THE DENTAL OFFICE. ONCE THE DVR MEMORY IS FULL, IT WILL RECORD OVER THE OLDEST RECORDED MATERIAL, THEREBY DESTROYING THE OLD MATERIAL. DR. SEGRERA, WILL MAINTAIN THE CAMERAS AND VIDEO EQUIPMENT AND ENSURE THAT THEY ARE FUNCTIONING PROPERLY. ONLY DR. SEGRERA IS AUTHORIZED TO REVIEW THE RECORDED MATERIAL. THERE MAY ARISE SITUATIONS WHEREIN THE RECORDED MATERIAL IS NECESSARILY USED IN THE REPORTING AND INVESTIGATION OF THEFT, ASSAULT, AND OTHER REPORTABLE INCIDENTS. DURING THESE INVESTIGATIONS, YOUR PRIVACY AS A PATIENT MAY BE COMPROMISED. IF THE RECORDED MATERIAL IS EVER USED IN THE REPORTING AND INVESTIGATION OF REPORTABLE INCIDENTS, DOCUMENTATION WILL BE MADE OF THE PERSONS WHO VIEW THE RECORDED SEGMENTS AND THEIR CREDENTIALS. ALSO, ALL PATIENTS VISIBLE IN THE REVIEWED SEGMENTS OF RECORDED MATERIAL WILL BE NOTIFIED THAT THEY WERE PRESENT IN THE VIEWED SEGMENTS AND GIVEN THE NAMES OF ALL PERSONS WHO VIEWED THE SEGMENTS. DR. SEGRERA WILL CONTINUOUSLY MONITOR THE SURVEILLANCE POLICIES AND PROCEDURES TO REDUCE THE RISK OF BREECHES OF PRIVACY.
CONSENT.

I, A PATIENT OF DENTAL CLINIQUE, UNDERSTAND THAT IN ORDER TO PROMOTE THE SAFETY OF EMPLOYEES AND PATIENTS, AS WELL AS THE SECURITY OF ITS FACILITIES, DENTAL CLINIQUE MAY CONDUCT VIDEO SURVEILLANCE OF ANY PORTION OF ITS PREMISES AT ANY TIME, WITH THE EXCEPTION OF RESTROOMS AND DRESSING ROOMS IF ANY ON PREMISES. ALL VIDEO CAMERAS WILL BE POSITIONED IN APPROPRIATE PLACES WITHIN AND AROUND DENTAL CLINIQUE PREMISES AND USED IN ORDER TO HELP PROMOTE THE SAFETY AND SECURITY OF PEOPLE AND PROPERTY. I HEREBY GIVE MY CONSENT TO SUCH VIDEO SURVEILLANCE AT ANY TIME THE COMPANY MAY CHOOSE.

I HEREBY RELEASE MARIA CLAUDIA SEGRERA DMD AND DENTAL CLINIQUE FROM ALL LIABILITY, INCLUDING LIABILITY FOR NEGLIGENCE, ASSOCIATED WITH THE ENFORCEMENT OF THESE POLICIES AND/OR ANY SEARCHES OR SURVEILLANCE UNDERTAKEN PURSUANT TO THESE POLICIES.

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Patient Name/ *Nombre del Paciente* **Patient Signature /** *Firma del Paciente* **Date** / *Fecha*