New Patient Questionnaire

Patient Name	Date of Birth	Age	Sex	Social Security Number **(REQUIRED)**
Primary Address	City	State	Zip Code	Home ( ) Work ( ) Cell ( )
Summer Address	City	State	Zip Code	Home
If Minor, Legal Guardian's Name		Email Address:		
Emergency Contact	Relationship	Emergency Contact Number		

Primary Dental Insurance: _______________________________		Secondary Insurance: ______________________________	
Policy Holder	Relationship to Patient	Policy Holder	Relationship to Patient
Policy Holder's SS Number	Policy Holder's Date of Birth	Policy Holder's SS Number	Policy Holder's DoB
Name of Employer	Group #		

How did you hear about our office? (Please check all that apply)	☐ Patient____________________	☐ Internet	☐ 1-800-Dentist
	☐ Doctor ____________________	☐ Drive-By	☐ Mailer
	☐ Parkwood Staff _____________	☐ Facebook	☐ Other__________
	☐ Insurance/Insurance Website	☐ Our website	_________________

I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies, for the purpose of filling and payment of medical claims. I authorize payment of dental benefits to Oscar Hernandez Jr., DMD or Parkwood Dental.

Payment is required for all services at the time they are rendered. **All applicable co payments and deductibles will be collected at the time of service.** Our terms are net 30 days. Late charges of 1.5% per month (18% APR) will be assessed on past due accounts, and collection charges and/or attorney fees may be added. **Appointments that are not cancelled 48 hours prior to the appointment time may be charged a $50 fee.** Your signature below signifies your understanding and willingness to comply with this policy.

I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, copays, coinsurances and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of service provided.

Signature of Patient or Legal Guardian ____ Date _____________

Patient ____ DOB _____________ Age_______ Today's Date___________

Medical History:

Are you under medical treatment now? ☐ Yes ☐ No If yes, for what_______________________________

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No

If yes, please explain: ____________________________

List all medications you are currently taking, including over the counter medications, vitamins, and natural or holistic remedies. Include dose and how often you take it. ____

____

Please list all Allergies to Medicines:

Medication: ____________________________ Reaction: ____________________________

____________________________ ____________________________

____________________________ ____________________________

Please check any medical conditions you had or currently are experiencing (attach sheet if necessary):

	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Arthritis	☐	☐	Artificial Joints	☐	☐
Asthma	☐	☐	Blood Disease	☐	☐	Cancer	☐	☐
Chest Pains/Angina	☐	☐	Diabetes	☐	☐	Dizziness	☐	☐
Epilepsy	☐	☐	Emphysema	☐	☐	Excessive Bleeding	☐	☐
Fainting	☐	☐	Glaucoma	☐	☐	Heart Injury	☐	☐
Heart Disease	☐	☐	Heart Murmur	☐	☐	Hepatitis	☐	☐
High Blood Pressure	☐	☐	Low Blood Pressure	☐	☐	HIV/AIDS	☐	☐
Jaundice	☐	☐	Kidney Disease	☐	☐	Liver Disease	☐	☐
Mental Disorders	☐	☐	Nervous Disorders	☐	☐	Pacemaker	☐	☐
Radiation Therapy	☐	☐	Respiratory Problems	☐	☐	Rheumatic Fever	☐	☐
Sinus Problems	☐	☐	Stomach Problem	☐	☐	Stroke	☐	☐
Thyroid Problem	☐	☐	Tuberculosis	☐	☐	Tumors	☐	☐
Ulcers	☐	☐	Venereal Disease/STD	☐	☐	Other ________________		

Social History: Do you smoke? ☐ No ☐ Former ☐ Yes: How many packs per day? _______

Do you drink? ☐ No ☐ Former ☐ Yes: How many drinks per day? _______

Women ONLY: Are you pregnant? ☐ No ☐ Maybe ☐ Yes Are you nursing? ☐ No ☐ Yes

Are you on Birth Control? ☐ No ☐ Yes Are you post menopausal? ☐ No ☐ Yes

Dental History:

Name of previous dentist: ____________________________ Date of last exam: ____________________________

Previous dentist's location: ___________________________ Date of last cleaning: __________________________

Has your medical doctor ever advised you to take **pre-medication** (antibiotics) before a dental procedure? ☐ Yes ☐ No

Reason for your visit today: ____

	Yes	No
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
Do you like your smile?	☐	☐
Do your gums bleed while brushing/flossing?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Do you clench or grind your teeth?	☐	☐

X________________________________ __________ X__________________________________ __________

Signature of Patient Date Signature of Dental Provider Date

PARKWOOD DENTAL

OSCAR HERNANDEZ, JR. D.M.D.

Welcome to Parkwood Dental

We would like to take this opportunity to thank you for selecting us as your personal dental care team. In order to promote a long-term, mutually satisfying relationship we would like to explain our office policy regarding your appointments, treatment and fees.

APPOINTMENTS

When scheduling your appointment(s), the time is reserved exclusively for you. If you fail to notify us of your inability to keep your appointment, it prevents us from treating another patient in need of emergency care and/or treatment. **If you are unable to keep your appointment, please notify us 48 hours in advance to avoid a $50.00 fee. If we are unable to confirm your appointment it may be given to another patient in need of treatment that we are able to confirm.**

TREATMENT

You will find Dr. Hernandez and our entire team dedicated to improving your oral health as quickly and effectively as possible with expert, sympathetic care. We will make every effort to make your appointments as comfortable and pleasant as possible. Please feel free to discuss your treatment with Dr. Hernandez or a member of our team at any time.

FEES

Payment is due at the time services are rendered and will be collected prior to receiving treatment. For your convenience we accept all major credit cards (Visa/ Mastercard/ American Express/ Discover), Debit Card, Personal Checks and Cash. In addition, financing options are available. Ask us about Care Credit Patient Payment Plans and Lending Club Patient Solutions.

DENTAL INSURANCE

If you have dental insurance we will be happy to bill your insurance company. Your deductible, co-payment and any other amounts not covered by insurance are due on the date of services rendered. This may or may not be an accurate amount. Even though an insurance claim has been submitted, you will receive a statement for the remaining balance due. **We will attempt** to have an estimate of your treatment portion with the information you and your insurance carrier have provided for us. **Ultimately it is the patient's responsibility to keep up with all of their insurance benefits and changes that may take place. We cannot and do not guarantee payments from insurance companies.** The insurance companies determine all benefits. Any claim that is denied immediately becomes responsibility of the patient and prompt payment is expected. **I (the patient) am aware that this service is being offered as a courtesy and that I am ultimately responsible for all services rendered.** If this account should become delinquent and/or past due, I agree to pay all costs of collection including, but not limited to, court costs, sheriff fees, collection fees, attorney's fees, and interest from the date of service in the amount of 18% per annum (1.5 % per month). We cannot compromise on your care, but we can do our best to help you get the benefits you deserve. **Our office is obligated to provide you with the treatment you need, but your insurance carrier is only obligated to pay what your policy contact calls for.**

Your confidence and trust in our office is greatly appreciated. Please sign below indicating that you have read and understand the policies of Parkwood Dental.

__________________________________ ________________________

Signature of Patient/Guardian Date

PARKWOOD DENTAL

OSCAR HERNANDEZ, JR. D.M.D.

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text is posted in our office.

We have adopted the following policies:

- Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information, which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
- It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
- The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
- You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
- You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
- Your confidential information will not be used for the purposes of marketing or adverting of products, goods or services.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____Date_____________________________ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.