PARKWOOD DENTAL

OSCAR HERNANDEZ, JR. D.M.D.

New Patient Questionnaire

Patient Name	Date of Birth	Age	Sex	Social Security Number (REQUIRED)	
Primary Address	City	State		Zip Code	Mobile ( ) Other ( )
Email Address:		If Minor, Legal Guardian's Name:			
Emergency Contact	Emergency Contact Number:	Relationship			Ok to share appointment info: ☐ YES ☐ NO

In the event our dentists prescribe medication, what is your pharmacy of choice?

Preferred Pharmacy Name:	Pharmacy Number:

Complete the following if you would like us to submit claims to your dental insurance:

Primary Dental Insurance: _____	Secondary Insurance: _____

How did you hear about our office?

(Please check all that apply)

☐ Patient_____ ☐ Internet

☐ PWD Staff _____ ☐ Drive-By

☐ Doctor _____ ☐ Spanish Radio

☐ FaceBook / Instagram / TikTok ☐ Other _____

Primary Reason for your visit with us today: _____

_____

Dental History:

Name of previous dentist: _____ Previous dentist's location: _____

Date of last exam: _____ Date of last cleaning: _____

I certify that the information I provided is correct. I understand payment is required for all services at the time they are rendered. 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 canceled 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.

Insurance: **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, and coinsurances. <u>All applicable co-payments and deductibles will be collected at the time of service.</u>** 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 dental claims. I authorize payment of dental benefits to Oscar Hernandez Jr., DMD or Parkwood Dental. **I understand that ultimately it is the patient's responsibility to keep up with all of their insurance benefits and changes that may take place. Parkwood Dental cannot and does not guarantee payments from insurance companies.**

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 <u>all</u> medications you are currently taking, including over the counter medications, vitamins, and natural or holistic remedies. Include dose and how often you take it: _____

_____

Have you ever needed to take pre-medication (antibiotics) before dental treatment ? ☐ Yes ☐ No

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	☐	☐	Fainting	☐	☐
Glaucoma	☐	☐	Heart Injury	☐	☐	Heart Disease	☐	☐
Heart Murmur	☐	☐	Hepatitis	☐	☐	HIV/AIDS/STD	☐	☐
High Blood Pressure/Low BP	☐	☐	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	☐	☐	Other	☐	☐

Are you taking any medication for bone density/biphosphonates? ☐ Yes ☐ No

Social History: Do you smoke? ☐ Yes ☐ Former ☐ No If yes, how many packs per day? _____

Do you chew tobacco? ☐ Yes ☐ No Do you drink? ☐ Yes ☐ Former ☐ No

Women ONLY: Are you pregnant/nursing ? ☐ Yes ☐ No ☐ Maybe pregnant Are you on Birth Control? ☐ Yes ☐ No

How often do you brush your teeth? _____ How often do you floss your teeth? _____

When was your last dental cleaning? _____ History of deep cleaning? ☐ Yes ☐ No

	Yes	No		Yes	No
Do your gums bleed while brushing or flossing?	☐	☐	Do you like your smile?	☐	☐
Are your teeth sensitive to hot/ cold liquids or sour/sweet foods?	☐	☐	Do you clench or grind your teeth?	☐	☐
Do you feel pain in any of your teeth?	☐	☐	Have you had any head, jaw, or neck injuries?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐	Have you had any orthodontic treatment?	☐	☐
Any difficult extractions or prolonged bleeding following extractions?	☐	☐	Do you have frequent headaches?	☐	☐
Have you ever experienced any of the following problems in your jaw?			Do you bite your lips or cheeks frequently?	☐	☐
Clicking	☐	☐			
Pain (joint, ear, side of face)	☐	☐			
Difficulty in opening or closing	☐	☐			
Difficulty in chewing	☐	☐			

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, compassionate 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, your treatment coordinator, or a member of our team at any time.

FEES

For your convenience we accept all major credit cards (Visa/ Mastercard/ American Express/ Discover), debit card, and Cash. In addition, financing options are available. We offer affordable payment options such as Care Credit & Lending Club and a Parkwood Dental preferred in-house no-interest plan.

Payment is due at the time services are rendered and will be collected prior to receiving treatment.

DENTAL INSURANCE

If you have dental insurance we will be happy to bill your insurance company. **However, 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. Parkwood Dental cannot and does 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

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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, _____ 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.

_____ _____

Signature of Patient/Guardian Date