YISELLE CASTILLO, D.D.S.

PATIENT INFORMATION (CONFIDENTIAL)

Name_____ M_____ F_____ Date_____

Address_____ City_____ State_____ Zip_____

Social Security #_____ Birthdate_____ Home Phone _____

Employer_____ Work # _____ Cell #_____

Business Address_____ City_____ State_____ Zip_____

Email_____ Referred By_____

Person to Contact for Emergency_____ Phone_____

INSURANCE INFORMATION

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____

Name of Employer_____ Work Phone_____

Insurance Company_____ Policy #_____ Group #_____

Insurance Company Address_____ City_____ State_____ Zip_____

Insurance Company Phone # _____ Do You Have any Additional Insurance? _____yes _____no

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____

Insurance Company_____ Policy #_____ Group #_____

Insurance Company Address_____ City_____ State_____ Zip_____

DENTAL HISTORY

Chief Oral Complaint_____

Date of Last Dental Visit_____ Cleaning_____ Full Mouth X-rays_____

Indicate with an (x) any of the following that apply

___Orthodontic Treatment	___Bleeding Gums	___Food Impaction	___Clenching/Grinding
___Periodontal Treatment	___Ear Pain	___Bad Breath	___Serious Injury to Head or Mouth
___Oral Surgery	___Swelling	___Sensitive Teeth	___Previous use of Gas/Nitrous oxide
___Bad Dental Experience	___Unpleasant Taste		

Are you satisfied with your teeth's appearance?..... Yes ___ No ___

Is there anything else about having dental treatment that you would like us to know?... Yes ___ No ___

If yes, please describe _____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past 2 years?... Yes ___ No___

If yes, for what? _____

Physician's Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past 2 years?.....Yes___ No___

3. Are you taking any medication, drugs, or pills now?.....Yes___ No___

If yes, please list name and dosage _____

4. Are you aware of having any allergic (or ADVERSE REACTION) to any medication or substance?
Yes___ No___

If yes, please explain _____

5. Have you been a patient in the hospital during the past 5 years?..... Yes ___ No ___

6. Indicate with an (x) which of the following you have had, or have at present:

Heart (Surgery, Disease, Attack) Yes ___	Ulcers..... Yes ___	Hepatitis A or B (serum).....Yes___
Chest Pain..... Yes ___	Diabetes..... Yes ___	Venereal Disease.....Yes___
Congenital Heart Disease..... Yes ___	Thyroid Problems.. Yes ___	A.I.D.S.....Yes___
Heart Murmur..... Yes ___	Glaucoma..... Yes ___	H.I.V. Positive.....Yes___
High Blood Pressure..... Yes ___	Contact Lenses.....Yes ___	Herpes (cold sores).....Yes___
Mitral Valve Prolapse..... Yes ___	Emphysema.....Yes ___	Blood Transfusion.....Yes___
Artificial Heart Valve..... Yes ___	Chronic Cough..... Yes ___	Hemophilia.....Yes ___
Heart Pacemaker..... Yes ___	Tuberculosis..... Yes ___	Sickle Cell Disease..... Yes___
Rheumatic Fever..... Yes ___	Asthma..... Yes ___	Bruise Easily.....Yes ___
Arthritis/Rheumatism..... Yes ___	Hay Fever..... Yes ___	Liver Disease.....Yes ___
Cortisone Medicine..... Yes ___	Latex Sensitivity.... Yes ___	Yellow Jaundice.....Yes___
Stroke..... Yes ___	Allergies/Hives..... Yes ___	Neurological Disorders.....Yes___
Artificial Joints (hip, knee, etc)... Yes ___	Sinus Trouble..... Yes ___	Epilepsy/Seizures.....Yes___
Kidney Trouble..... Yes ___	Fainting/Dizziness.. Yes ___	Nervous/Anxiety.....Yes___
Radiation/Chemotherapy..... Yes ___	Tumors..... Yes ___	Psychiatric/Psychological Care..Yes___

7. Have you lost or gained more than 10 pounds in the past year?..... Yes ___No____

8. Do you have, or have you had any disease, condition, or problem not listed..... Yes ___No____

If yes, please explain_____

9. **WOMEN** Are you: Pregnant? Yes ___ # of months____ Nursing? Yes ___ Birth Control Pills? Yes____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my health or medication.

X_____ _____

SIGNED (PATIENT OR PARENT IF MINOR) DATE

INSURANCE: To avoid any misunderstanding regarding dental insurance, we wish our patients to know that **ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT AND THAT PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES.** We will prepare the necessary forms or reports to help you obtain your benefits from an insurance company upon full (or partial if accepting assignment) payment of bill. ***WE DO NOT RENDER OUR SERVICES ON THE BASIS THAT INSURANCE COMPANIES WILL PAY OUR FEES.*** Each fee is specific for the individual patient.

In the event that an unpaid balance is submitted to our collection agency you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.

APPOINTMENTS: A minimum charge of **SEVENTY FIVE DOLLARS** will be made for failed or cancelled appointments without prior notification of 24 hours. This fee will cover only the portion of the overhead such as salaries, electric, heat, etc. which still has to be paid whether you are present or not. Once the appointment has been made, this time is reserved for you.

X_____ Date_____
SIGNED (PATIENT OR PARENT)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES **(HIPAA COMPLIANCE)**

I have received a copy of this office's Notice of Privacy Practices

X_____ Date_____
SIGNED (PATIENT OR PARENT)

You have a right to request a copy of this office's HIPAA Privacy Practices

Dear Patient,

In an effort to provide you with quality dental care and flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

- **Payment by Cash**
- **Payment by Check**
- **Payment by Credit Card (VISA, MASTERCARD, AMERICAN EXPRESS)**
- **Automatic monthly billing to your Credit Card**
- **Guarantee your insurance co-payment with Credit Card**
- **Care Credit Loan (1 year interest free loan)**
- **Insurance Assignment (must be approved by treating dentist)**

I AUTHORIZE THE RELEASE OF ANY INFORMATION TO ANY CLAIM

X_____
SIGNED (PATIENT, OR PARENT)

I AUTHORIZE PAYMENT TO THE DENTIST

X _____
SIGNED (INSURED PERSON)

Our office is fully approved and accredited user of the *VISA/MASTERCARD* Health Care Incentive Program (Care Credit) that will enable you to use your *VISA/MASTERCARD* to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your *VISA* or *MASTERCARD* on a monthly basis. If none of the above options applies, please see the receptionist.
Thank you.

Yiselle Z. Castillo, DDS
110 East 40th Street, Suite 103
New York, N.Y. 10016

CONSENT FOR DENTAL TREATMENT

Please read carefully and ask any question you may have. Dr. Yiselle Z. Castillo will be more than glad to answer your questions.

1. I authorize Dr. Yiselle Z. Castillo assisted by their auxiliary personnel to perform the following dental and/or surgical procedures on my son/daughter or I, this includes the use of local anesthesia, radiographs or any other diagnostic aide.
2. In general terms, the dental procedures and/or surgical include:
    a. Pedodontic prophylaxis (cleaning) and topical fluoride application (to minors).
    b. Scaling and root planning.
    c. Dental restorations (Amalgams, composite, post and crowns)
    d. Replacement of missing teeth with fixed or removable restorations.
    e. Space maintainers.
    f. Extractions.
    g. Treatment of affected oral tissues.
    h. Bleaching treatment.
    i. Other _____ .

These procedures have been explained to me as well alternate methods of treatment with their advantages and disadvantages. I have been informed that although we expect a good result, there are always possible complications and there is no absolute guarantee on any of the treatments.

Dr. Yiselle Z. Castillo is authorized to render any services she deems necessary
Except _____.

3. Even though it is extremely rare, there are known risks associated to dental treatment including local anesthesia. The risks for example are: Numbing of the area, infection, swelling, bleeding, allergic reactions, discoloration, etc.

I understand and accept that these complications may require specialized medical treatment. I have read and understand this authorization and that all my questions regarding the procedure have been answered to my satisfaction. I understand I have the right to get my answers to any question that may arise during the course of treatment.

DATE _____ TIME_____
Patients Name _____
Name of parent or guardian _____
Signature _____

I certify that the above mentioned procedures have been explained to the patient and parent or guardian before requesting their signature.

_____

Yiselle Z. Castillo, DDS