Welcome!

Thank you for choosing our office. We are honored for the opportunity to provide gentle, quality dental care. If you have any questions or we can help you in any way, please feel free to ask our doctors or staff.

Dr. Andrea D. Gordillo D.M.D., PA & Associates

Patient Information (Confidential):

Name ______________________________________ (If child, parent/guardian name) __________________________
Last name First name *Last name First name*

Birthdate ___________________ Sex _________ Age _______ Soc Sec # _______________Marital Status_______
Home Address ____________________________________ City __________________ State ______ Zip __________
Home Phone ________________ Work Phone _______________ Cell Phone ________________
Email _______________________________ Would you like us to confirm your appointment with email? ___________

Employer _____________________ Occupation ________________How long there? ______ May we call? _________
Employer Address _____________________________________ City ________________ State _____ Zip __________

Spouse's Name (Or parent/guardian) _______________________ Soc Sec # _______________ Birthdate ___________
Spouse's Employer __________________ Occupation ______________How long there? ______ May we call? _______
Employer Address _____________________________________ City ________________ State _____ Zip __________

If patient is a student: Name of School/College: ____

In case of emergency:
Nearest Relative Not Living With You: _______________________ Relationship ___________ Phone _______________
Address ____

Nearest Friend Not Living With You: _______________________ __________ Phone _______________________
Address ____

How did you hear about our practice? ____

Primary Insurance (Dental):

Name of Insured: ________________________________
Birthdate: ______________
Relationship to patient _______________
Employer _____________________________________
Address (if different than patient) ______________________
Social Security # __________ Subscriber ID _____________
Group, Contract , Local or Union # _____________________

Additional Insurance (Dental):

Name of Insured: ________________________________
Birthdate: ______________
Relationship to patient ________________
Employer _____________________________________
Address (if different than patient) ____________________
Social Security # __________ Subscriber ID _____________
Group, Contract , Local or Union # _____________________

Name and City of primary care physician ____

Someone we may contact, not living with you: _________________________ Phone # ___________________________

Authorization:

Please present this form, your driver's license and all insurance ID cards to the receptionist at this time. Please read the following authorization and sign the form where indicated.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collections costs if this office determines they are necessary. Our office can only ***estimate*** insurance benefits, and therefore can not guarantee your portion. I authorize my insurance company to make payments directly to Dr. Gordillo and Associates for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I have read and understand the above and agree to comply.

X ____ ____________________________
Patient Signature Date

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Dental History (Confidential):

Patient Name ____ Age _______ Date _________________

Reason for seeking care today: Exam _____ Cleaning _____ Specific Problem __________________________________
(Please Describe)

Date of last visit to the dentist _________________________ Reason for your last visit ___________________________

Do you have x-rays or dental records ___________________

Please check all that apply:

- ☐ Toothache
- ☐ Broken filling or tooth
- Sensitivity to:
  - ☐ Cold
  - ☐ Hot
  - ☐ Sweets
  - ☐ Chewing
- ☐ Food catches
- ☐ Loose teeth
- ☐ Floss breaks easily or hurts
- ☐ Bite or teeth have shifted
- ☐ Often bite cheeks
- ☐ Frequent dry mouth
- ☐ Concerned about breath
- ☐ Unhappy with previous dental work
- ☐ Gums bleed
- ☐ Gums tender
- ☐ Growths, sores
- ☐ Cold sores, fever blisters
- ☐ Cracked, chapped lips
- ☐ Bad taste in mouth
- ☐ Sinus problems
- ☐ Mouth breathe-Difficulty breathing through nose
- ☐ Dry or strained eyes
- ☐ Shoulder, neck or headaches
- ☐ Clench or grind teeth
- ☐ Jaw joint pain
- ☐ Clicking or popping of joint
- ☐ Unable to open mouth wide
- ☐ Jaw gets tired easily
- ☐ Hold things between teeth (Pipe, pencil, nails, pins)
- ☐ Bite fingernails
- ☐ Unusual habits with teeth
- ☐ Wore braces
- ☐ Previous gum treatment
- ☐ Previous bite treatment

Have you ever fainted? ________________________ Had an allergic reaction to anesthetics? ___________________

Would you like whiter teeth? _______ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile? ____

Please rate 1-10 how anxious you are about dental treatment (1= totally relaxed) ____________

Why did you leave your previous dentist? __________________________

Did your parents have difficulties with their teeth or dental treatments? ________________________

Medical History (Confidential):

Physicians Name: ___________________________

City _____________________ Phone __________

Have you been hospitalized for any reason? _______

Please Describe: ____________________________

____

Are you taking any medications or drugs (including nutritional supplements?) Please list: (Continue on back of form if needed) ____________________________

____

____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other? ______________________________________

Do you smoke? How much/day? _____________________________

Pregnant? Due Date __________ Are you nursing? _____________

Are you seeing a physician now or planning to see one for any reason?

Please explain: ____

____

____

____

____

Write YES for all that apply:

Latex Allergy ______	Irregular Heartbeat ______	Bleeding Problems ______	Cancer ______
Joint Replacement ______	Atrial Defibriation ______	Asthma ______	HIV or AIDS ______
High/Low Blood Pressure ______	Pacemaker ______	Lung Disease ______	Acid Reflux ______
Heart Attack ______	Artificial Heart Valve ______	Liver Disease _______	Epilepsy ______
Angina ______	Congenital Heart Disease ______	Hepatitis ______	T.B. ______
Heart Murmur _____	Blood Disorder ______	Kidney Disease ______	Use Tobacco ______
Mitral Valve Prolapse ______	Stroke ______	Digestive Disorders ______	Nickel Allergy ______
Diabetes ______	Snoring/Sleep Apnea _______	Atrial Defib. Drugs ______	Blood Thinners ______
Glaucoma ______	Fainting or Dizzy ______	Osteoporosis Drugs ______	Chemotherapy ______
Drug/Alcohol Addiction ______	Depression ______	Birth Control Medications ______	Radiation Treatment _____

Any other illnesses not listed above: ____

____

____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: ☐ Yes ☐ No

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (Parent/Guardian) ____________________________________ Date ____________________

Dentist Signature ____ Date ____________________

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Dental Laser Center Office Guidelines

Appointments: The majority of our patients honor their obligation by keeping their dental appointments. The appointment time reserved is exclusively for you.

- **Appointment Confirmation Courtesy** – As a courtesy, we call our patients to confirm their appointments.
- **Broken Appointments** – Appointments not honored or that are cancelled with less than 24 hour notice may result in a broken appointment fee of $50.00
- **Appointment Tardiness** – Arrival after 15 minutes for an appointment may require us to reschedule the appointment or modify procedures for the time remaining.

Insurance: We will file your insurance claim as a courtesy, collect the estimated patient co-payment and coordinate any balance billing.
Network Dental Plans: Our office is in network with some dental insurance carriers. We are In Network with the following:

- **MetLife**
- **Cigna**
- **Delta Dental**
- **Guardian**
- **Aetna**
- **United Concordia**
- **Assurant DHA**

We will accept other dental insurances as a form of payment. You will be responsible for the difference if your dental carrier does cover in full. We are not in network with any managed care plans (HMO's) and cannot accept that policy as a form of payment.

I have read and understand the office guidelines.

Signature ______________________________________ **Date** ____________________

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Financial Policy

Our office is pleased to enable you to utilize your dental insurance to help pay for your dental treatment. Our staff is highly trained in the complexities of dental insurance to provide prompt, efficient service. Understanding your policy can be difficult and confusing. Our policy regarding your coverage is as follows:

1. Rarely does dental insurance cover **ALL** of your dental expense.
2. Most plans have deductibles and co-insurance payments which **MUST** be met by you at the time of service.
3. **The portion of the bill covered by insurance is only an estimate. No one can guarantee coverage!**
4. ***The insurance policy is an agreement between you and your insurance carrier. Your insurance does not guarantee any payment to us.***
5. **Any remaining balance after payment from your insurance is YOUR RESPONSIBILITY. YOU ULTIMATELY ARE RESPONSIBLE FOR YOUR ACCOUNT BALANCE. PAYMENTS ON REMAINING BALANCES ARE DUE IMMEDIATELY UPON RECEIPT.**

We accept most PPO insurances as a courtesy to our patients. This may or may not make a difference in your out-of-pocket expense. _____________ (Initials)

We will try to make the most of your insurance coverage. It is a benefit you have earned. Any questions should be directed to our front desk personnel.

Thank you very much for your continued patronage.

I hereby authorize payment directly to Andrea D. Gordillo, D.M.D. and Associates, insurance benefits which would be otherwise payable to me. I have read and understand this agreement. I fully accept responsibility for my insurance coverage and agree to pay any remaining balance immediately.

(Insured Person) ____________________________ ***(Legal Guardian of Minor/Dependent)*** ___________________

Date: ____________________

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HIPAA PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment:;
- Obtaining payment from third party payers (e.g. my insurance company);
- The day to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the term of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

As of May 1st 2009, new federal guidelines require photo ID at your initial visit.

Date: ______________________

Patient Name (Print): ____________________________

Signature: ___________________________________

Relationship to Patient: _________________________

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