Reyes Dental Group

Patient Information

Patient Name: Date
Last, First MI (Preferred Name)
Gender: Family Status:
Social Security #: Birth Date:
Phone (Home): (Work): Ext: (Cell): _____
Email: _____
Address:
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: Reason for today's visit:

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV Positive
- ☐ Medication Allergies
  _____
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners:
  Name_____
- ☐ Cancer
  Type_____
- ☐ Dental Anxiety
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ GERD
- ☐ Stroke
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Tobacco Use
  Type_____
- ☐ Tuberculosis
- ☐ Tumors
- ☐ HPV

OTHER:

- ☐ _____
- ☐ _____

· Do you require antibiotic pre-medication for previous heart infections, heart defects you were born with, replacement heart valves, or joint replacements (include date of placement)? _____

· Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:

· Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

· Please list all medications or provide list: _____

_____

_____

· Have you ever taken or are you currently taking medication for osteoporosis (i.e. Fosamax, Boniva)? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:
Signature of patient, parent or guardian

In case of emergency, please contact: Name:_____ Phone #: _____

Whom May We Thank for Referring You to our office?

☐ Google Ad ☐ Other _____

☐ Google Search ☐ Family Member _____

☐ Yelp ☐ Staff Member _____

☐ Zocdoc ☐ Doctor Referral _____

Best Form of Communication for Appointment reminders

☐ Text Message_____ ☐ Email _____

☐ Phone Call _____

Policy Holder or Responsible Party Information

The following is for: ☐ the policy holder ☐ the person responsible for payment

Name:

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ **Birth Date**:

Phone (Home): _____ (Work): _____ Ext: _____

Address:

Street Apartment #

Employer Name and Address: _____

City State Zip Code

Dental Insurance Company: _____ **Phone Number** _____

Identification Number: _____ **Group or Plan Number:** _____

Secondary Insurance

Employer Name and Address: _____

Policy Holder Name _____ **Date of Birth:** _____

Dental Insurance Company: _____ **Phone Number:** _____

Identification Number: _____ **Group or Plan Number:** _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Larry G. Reyes DDS PLC, provides insurance company billing as a courtesy to our patients. The patient portion of particular dental services is estimated, and due at the time of service. This amount may be subject to an adjustment when the dental service(s) claim is finalized by the insurance company. In addition, certain insurance companies have annual limitations for the amount of dental services that can be reimbursed within each plan year. If you or a family member exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed those particular plans limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not fully rely upon any information provided by Larry G. Reyes, DDS PLC staff regarding his/her remaining benefit in any such benefit period.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient:

Signature of guarantor of payment/responsible party