BELTRAN DENTAL SURGERY

11424 N 56th Street
Temple Terrace, FL 33617
Office: 813-373-4573
Fax: 813-388-6825
www.beltrandentalsurgery.com

Patient Registration

Date: _____

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____ Sex: ◯ Male ◯ Female

Do you give Beltran Dental Surgery permission to contact you regarding your appointments via text or email? ◯ Yes ◯ No

Birth Date: _____ Social Security #: _____ Employer: _____

Student Status: ◯ Full Time ◯ Part Time Name of School: _____

How did you hear about us?_____

Referred By: _____ Previous Dentist: _____ Reason For Visit: _____

Emergency Contact: _____ Emergency Contact Phone: _____ Second Phone: _____

Responsible Party: ◯ Same as Above

Relationship to Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____ Sex: ◯ Male ◯ Female

Birth Date: _____ Soc Sec: _____ Employer: _____

Primary Insurance Information:

Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____ City, State, Zip: _____

Policy ID Number: _____ Group Number: _____ Effective Date of Coverage: _____ Cal/Fis Year

PPO/UCR Annual Maximum: $_____ Benefits Used to Date: $ _____ Deductible: $_____Met: Y/N Applies: Prev/Basic/Major

Medical History

First name: _____ Last name: _____ Age_____

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with oral surgery. Thank You for taking the time to answer the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes, who is your Medical doctor?	_____
Have you ever been hospitalized or had any operations?	○ Yes ○ No	If yes, why were you hospitalized or operated?	_____
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes, when and why?	_____
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes, when?	_____
Are you on a special diet?	○ Yes ○ No	If yes, please explain:	_____

Women: Are you Pregnant/Trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○ Yes ○No

List Medications prescribed to you by a Medical Physician:_____
_____
_____

Are you allergic to any of the following? ○Yes ○ NO
○ Aspirin ○ Penicillin ○ Codeine ○Eggs/Soy ○Metal ○Latex ○Local Anesthetics ○Sulfa-drugs ○Other: _____

Do you have, or have had, any of the following? Please circle ALL that apply

Cardiac
Chest Pains
Congenital Heart Disorder
Easily Winded
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
High Blood Pressure
Irregular Heartbeat
Low Blood Pressure
Mitral Valve Prolapse
Rheumatic Fever

Cognitive / Psychiatric
Alzheimer's Disease
Convulsions
Drug Addiction
Epilepsy or Seizures
Fainting Spells/Dizziness
Frequent Headaches
Psychiatric Care
Stroke

Dermatologic
Cold Sores/Fever Blisters
Herpes Scarlet Fever
Hives or Rash
Shingles
Venereal Disease
Ulcers

Endocrine
Cortisone Medicine
Diabetes
Excessive thirst
Hypoglycemia
Parathyroid Disease
Thyroid Disease

Respiratory
Asthma
Chest Pains
COPD
Easily Winded
Frequent Cough
Hay Fever
Emphysema
Lung Disease
Tuberculosis

Bleeding / Circulatory
Anaphylaxis
Anemia
Blood Disease
Hepatitis A
Hepatitis B or C
Hemophilia
High Blood Pressure
Leukemia
Lymphoma
Sickle Cell Disease
Blood Transfusion
Bruise Easily

Muscle / Joint
Arthritis
Gout
Artificial Heart Valve
Artificial Joint
Pain in Jaw Joints
Rheumatic Fever
Rheumatism
Spina Bifida
Swelling of Limbs

Digestive / Hepatic/Urinary
Frequent Diarrhea
Excessive Thirst
Kidney failure
Liver Disease
Renal Dialysis
Stomach Disease
Intestinal Disease
Irritable Bowel Syndrome
Stomach Ulcers
Yellow Jaundice

Other
AIDS/HIV Positive
Drug abuse
Glaucoma
Radiation Treatments
Recent Weight Loss
Sinus Trouble
Tonsillitis
Tumors or Growths

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, what illness: _____

Have you had any type of Cancer or chemotherapy? ○ Yes ○ No If yes, what type? _____

Have you ever had sleep apnea or do you snore when you sleep? ○ Yes ○ No If yes, please explain: _____

Have you ever had head or neck radiation? ○ Yes ○ NO If yes, when and how many treatments: _____

Have you ever had bisphosphonate therapy (FOSAMAX, AREDIA, ZOMETA) or medications to strengthen your bones? ○Yes ○NO

Have you ever or do you currently smoke or use tobacco of any kind? (dipping tobacco, hooka, e-cigs, vapes, etc.) ○ Yes ○No
If yes, please clarify what product, frequency, and how much? _____

Do you consume alcohol? ○ Yes ○ NO If yes, how many per day/week or month? _____

Have you ever used any Recreational Drugs? ○Yes ○NO If yes, which ones? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____DATE_____

BELTRAN DENTAL SURGERY

FINANCIAL POLICY

Thank you for choosing Beltran Dental Surgery as your dental health care provider. We are committed to providing you with the most comprehensive dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment and this financial agreement is intended to facilitate our ability to provide excellent service to you.

Please initial each section:

____Payment is due prior to the service provided. Our office accepts cash, Visa, and MasterCard and debit card with Visa/MasterCard logo. Financing is also available through Care Credit and Lending Club upon approval.

____We must emphasize that **our service is to you, our patient**, **not your insurance company.** Deductibles, co-insurances and /or co-payments are expected at the time of service. All charges you incur are **your responsibility** regardless of your insurance coverage. As a ***courtesy,*** Beltran Dental Surgery will file on your behalf to your insurance company. Please understand that we will provide an insurance coverage estimate to you, however, this estimate is **NOT** a guarantee that your insurance will pay exactly as estimated.

____The Treatment Plan estimate is valid for 90 days from the proposed date. Your co-payment amount may possibly be adjusted upon the final insurance payment. Your insurance company ultimately determines how much the insurance pays and how much you pay. If you are issued a credit on your account after all payments have been received, It is the your responsibility to request a refund before 90 days or the refund will no longer be available as a credit to your account.

____As a **courtesy** to you, we will **HELP** you process insurance claims, but please remember, your dental insurance plan is a contract between you, your employer, and your dental insurance company. Our office is **NOT** a party to that contract. If payment from your insurance company is not received within 30 days, you will be expected to pay balance in full.

____We ask that you inform us immediately with any changes in your insurance coverage. Failure to do so may result in the inability of our office to file your claim, and thus you will be responsible for payment in full regardless of your insurance situation.

____When scheduling any procedure, the procedure fee will be collected ***IN FULL*** to schedule the appointments. Patients who cancel or reschedule their appointment in less than 48 business hours prior to the time of the appointment will lose a **non-refundable $200.00 portion** their deposit.

____Balances older than 30 days will **BE PENALIZED $35.00 EVERY 30 DAYS**. If your account becomes past due, we will take the necessary steps to collect this debt. In case it becomes necessary for our office to enlist the services of a collection service or litigation or report you to the Federal Credit Bureau, you will be responsible for any collection/court cost or attorney fees associated with such outstanding balances. You grant us permission to release all necessary protected health information, including but not limited to treatment plan or treatment notes, to these companies or agencies.

____***I HAVE READ, UNDERSTAND, HAVE HAD ALL MY QUESTIONS ANSWERED ABOUT THE FINANACIAL AGREEMENT AND ACCEPT THE FINANCIAL POLICY OF BELTRAN DENTAL SURGERY.***

Name of patient or responsible party:_____ Date: _____

Signature:_____

BELTRAN DENTAL SURGERY

Informed Consent and Release for Three Dimensional X-Ray (iCAT)

At Beltran Dental Surgery, we strive to offer our patients the highest technology when diagnosing treatment for your dental care. This may require the acquisition of a three dimensional x-ray to better view the dental area that requires diagnosis. If Dr. Beltran requires one of these x-rays, he will discuss this with you during the time of your exam.

I, _____, authorize Jose Luis Beltran, DMD, MD, LLC, and any associates to perform the acquisition of a three-dimensional x-ray (also known as tomogram, CT scan, CBCT or iCAT) for the purpose of a limited evaluation, diagnosing, and documentation of my area of treatment.

____ I would like the three-dimensional x-ray reviewed by an expert dental radiologist, who will review the x-ray in its entirety, and I will be responsible for the fees incurred.

____ I waive the right to have the three-dimensional x-ray read by a dental radiologist expert. If for any reason there is pathology or any other abnormal radiographic findings that is not identified by a non-expert dental radiologist (hence, Dr. Beltran and his associates), then I release them of any responsibility.

_____ _____
Patient or Guardian Signature Date

_____
Witness

Informed Consent and Release for Photographic Pictures

During your treatment at Beltran Dental Surgery, Dr Beltran may take photos for treatment documentation.

I, _____, authorize Jose Luis Beltran, DMD, MD, LLC, and any associates to perform the acquisition of photographic pictures for the documentation of my treatment.

_____ _____
Patient or Guardian Signature Date

_____
Witness

BELTRAN DENTAL SURGERY

Patient Acknowledgement of Notice of Privacy Practices

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care options.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.

My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

- The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

My diagnosis, treatment, and medications may be discussed with?

First and Last Name and relationship:_____

_____

_____

Patient Signature: _____ Date:_____

Patient's Name Printed Out: _____

Witness: _____

BELTRAN DENTAL SURGERY

AUTHORIZATION TO OBTAIN AND THE RELEASE OF INFORMATION & CONSENT TO RECEIVE, MAIL, OR TELEPHONE MESSAGES

I hereby authorize Beltran Dental Surgery to release any/all of my medical/dental information for the purpose of:

- Any request from my insurance company
- Any Dentist, Physician, or Specialist I am referred to (General Dentist, Endodontist, Periodontist, Oral Surgeon)

I understand that the information that may be released may include confidential medical/dental information that was provided by me. I hereby release Beltran Dental Surgery from all legal responsibility or liability that may arise from the action I have authorized above. I also give consent to receive mail or telephone messages from Beltran Dental Surgery.

PATIENT NAME:_____ Date:_____

SIGNATURE:_____

Witness: _____