ENGLISH

Confirming Appointments:

Patients will be notified by voice-mail 48 hours prior to their scheduled appointment. Patients will need to confirm 24 hours prior to their appointment with a confirmation call or a message on our answering system. Patients acknowledge unconfirmed appointment will be offered to other patients.

Missed Appointments:

Patients who miss their appointments (no-shows) will be charged $50 per no-show. Patients who accumulate 3 or more missed appointments (no-shows) will only be scheduled with doctor's approval.

Patient Information:

Patients are responsible for informing our office of any changes in contact information.

Waiting Room:

All children and legal guardians not being seen in the treatment rooms must remain in the children's waiting room. Only the patient/child being treated is allowed in the treatment room, unless the legal guardian is needed.

_____ _____

Patient/Legal Guardian Signature Date

SALAZAR DENTAL GROUP

Patient Information

Patient Name: _____ Date: _____
Last First MI

___ Male ___ Female ___ Married ___ Single ___ Child ___ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Reason for this visit: _____ Date of Last Dental Visit: _____

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

___ AIDS
___ Allergies(meds,other)
___ Anemia
___ Arthritis
___ Artificial Joints
___ Asthma
___ Blood Disease
___ Cancer
___ Diabetes
___ Dizziness,Fainting
___ Epilepsy
___ Excessive Bleeding
___ Glaucoma
___ Growths
___ Hay Fever
___ Head Injuries
___ Heart Attack
___ Heart Disease
___ Heart Murmur
___ Hepatitis
___ High Blood Pressure
___ Jaundice
___ Kidney Disease
___ Liver Disease
___ Mental Disorders
___ Nervous Disorders
___ Pacemaker
___ Pregnancy
___ Radiation/Chemo Tx
___ Respiratory Problems
___ Rheumatic Fever
___ Rheumatism
___ Sinus Problems
___ Stomach Problems
___ Stroke
___ Tuberculosis
___ Tumors
___ Ulcers
___ Mitral Valve Prolapse
___ Previous Endocarditis
___ Prosthetic Cardiac Valve
___ Other _____

If you checked any of the above, please explain: _____

_____

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

Have you been admitted to a hospital or needed emergency care during the past two years? ___ Yes ___ No
If yes, please explain: _____

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

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ___ Yes ___ No
If yes, please explain: _____

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/staff at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Referral Information

Whom may we thank for referring you to our practice? How did you hear about our practice?

_____
Person, Dental Office, Yellow Pages, Internet, Other

Responsible Party Information

Please fill out if different from Patient Information

Name: _____

___ Male ___ Female ___ Single ___ Married ___ Parent ___ Guardian ___ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

Primary Insurance:

Name of Insured: _____ Is insured a patient? ___ Yes ___ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip

Insured's Employer Name: _____

Employer Address: _____

Street City State Zip

Patient's relationship to insured: ___ Self ___ Spouse ___ Child ___ Other _____

Insurance Plan Name and Address: _____

_____

Secondary Insurance:

Name of Insured: _____ Is insured a patient? ___ Yes ___ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip

Insured's Employer Name: _____

Employer Address: _____

Street City State Zip

Patient's relationship to insured: ___ Self ___ Spouse ___ Child ___ Other _____

Insurance Plan Name and Address: _____

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 rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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 exam.

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 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

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICINES YOU ARE CURRENTLY TAKING ON A REGULAR OR DAILY BASIS.

PRESCRIBED MEDICATIONS

OVER THE COUNTER (INCLUDE ALL VITAMINS AND MINERALS)

SIGNATURE: _____ DATE: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

Salazar Dental Group, LLC

6799 Great Oaks Rd | Suite 201 | Memphis, TN 38138 (901) 753-0404

Dental History and Concerns

1. When was your last dental visit? Was this an Emergency visit or a routine dental check up? Date of last cleaning.

2. Do you have any dental concerns? If so, please Explain.

3. Are you having pain or discomfort anywhere in your mouth? If yes, where?

4. What is your primary concern with your mouth?

5. Are you happy with the appearance of your smile? Is there anything you would like to change?

6. Are you interested in whiter teeth? Have you ever tried whitening your teeth before? If so, what did you use? Did you achieve the desired results?

7. Are you interested in straighter teeth? Have you ever worn braces? Would you be willing to wear braces to achieve this?

8. Is there anything else that you feel is important and that we should know about? Please describe.

Name: _____ Date: _____

Signature: _____