Alfredo Vico D.D.S.

Patient Information

Date_____ Home Phone (___)_____Cell (___)_____ Work (___)_____
Patient name_____ SSN_____
Address_____email _____
City_____State_____ Zip _____
Date of Birth_____ Age_____ Sex_____ Employer_____ Occupation_____
Emergency Contact _____Relationship _____ Phone (___)_____
How did you find out about our practice? _____
Preferred method of contact for appointment reminders_____

Dental Insurance

Subscriber name_____Relationship to patient _____
Subscriber address _____Phone (_____)_____
City _____State_____Zip_____
Employer _____ Employer Phone(____)_____Occupation_____
Insurance Company_____ Phone (_____)_____
Subscriber ID _____Group ID _____SSN_____
Names of all dependents covered_____

I certify that I, and/or my dependent(s), have insurance coverage with the above listed insurance company and assign directly to Dr. Alfredo Vico all insurance benefits. I understand that I am financially responsible for all charges that are not paid by my insurance. I understand that copayments are a contractual obligation set by the insurance policy and are due in full at the time of the treatment. I authorize the use of my signature and any of my other information on all insurance submissions.

Print name _____ Signature _____ Date_____

Dental History

Reason for today's visit _____
Date of last dental care _____ Date of last dental x-rays _____

1. Are you currently experiencing dental pain or discomfort? Yes/No
2. Do your gums bleed? Yes/No
3. Are your teeth loose? Yes/No
4. Do you wear dentures or partials? Yes/No
5. Have you ever been told you have gum disease? Yes/No
6. Are your teeth sensitive to hot, cold, sweets or pressure? Yes/No
7. Have you ever had any clicking, popping or discomfort in the jaw? Yes/No
8. Do you brux or grind your teeth? Yes/No
9. Do you wear an occlusal guard? Yes/No
10. Have you ever had orthodontic treatment (braces) before? Yes/No
11. Do you have dry mouth? Yes/No
12. Does food or floss catch between your teeth? Yes/No
13. Have you had any problems or an upsetting dental experience associated with previous dental care? Yes/No
14. Are you fearful of dentistry or have anxiety associated with dental treatment? Yes/No
15. Do you use any dental home care products other than toothpaste, floss or mouthwash? Yes/No
16. Have you ever had a reaction to anesthetic used with your dental treatment? Yes/No
17. Are you happy with your smile? Yes/No
18. What would you change about the present condition of your mouth? _____

Medical History

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what?_____
   Date of last medical exam?_____Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

Have you experienced:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

Do you or have you had:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, latex? _____	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	50.	Yes	No	Diabetes?

Do you or have you had:

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?

Are you taking:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	No	Alcohol?

Please list:_____

Women only:

65. Yes No Are you or could you be pregnant or nursing? 66. Yes No Taking birth control pills?

All patients:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient signature:_____

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General Consent

I, _____, consent to be a patient at the above-named Dental practice and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____
Signature of patient or responsible party Date

_____ _____
Witness Date

Payment Policy

Thank you for choosing us as your dental care provider. We are committed to providing you with quality and affordable dental care. Please carefully review our payment policies and let us know if you have any questions.

Insurance: We understand there is often confusion when it comes to dental insurance benefits. We are more than happy to assist you in understanding the benefits your policy offers. We are happy to file a claim to your insurance company as a courtesy to you, but we are unable to guarantee payment. We will do our best to estimate what your insurance will pay in assisting with your treatment costs as well as what your portion will be. You are, however, financially responsible for your treatment.

Insurance benefits are not determined by our office**.** No insurance pays 100% of all procedures. Dental insurance is meant to be an aid in reducing the cost of dental care. Many patients believe that their insurance pays for all, or most, dental fees. Unfortunately, most plans only pay between 50-80% of the contracted fee for each procedure. In addition, most insurance plans will not pay more than $1500 to $2000 in benefits per year. Dental treatment can often far exceed this amount. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.

We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

1. **Co-payments and deductibles**: In order to receive benefits from your insurance company, you are required to pay your copayment, coinsurance and/or deductible. This arrangement is part of your contract with your insurance company. **Failure on our part to collect co-payments and deductibles from patients can be considered fraud**. According to the American Dental Association, non-collection of insurance copays is considered illegal overbilling and is fraudulent. Your insurance can refuse to pay if you do not pay your portion. All co-payments and deductibles must be paid at the time of service.
2. **Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by insurers. You must pay for these services in full at the time of visit.
3. **Proof of insurance**: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. **Claims submission**: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
5. **Coverage changes**: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you

Non-payment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Refunds: I understand that if I choose to discontinue treatment or change my treatment plan at any time, I will forfeit any discounts given and the Usual and Customary prices will reflect in the balance due and any refund will be determined upon review of my case.

Missed appointments: Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. For your convenience, we accept cash, personal checks with a valid ID, and most major credit cards. We also offer financing through Care Credit.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Cancellation and No-Show Policy

Our goal is to provide quality individualized dental care in a timely manner. Late cancellations and No Shows (including arriving more than 20 minutes late) create inconvenience and prevent scheduling of other patients who need access to dental care in a timely manner. We understand situations may arise when you may need to cancel your appointment and we appreciate advanced notice when that happens. This helps us to be respectful of other patients' needs and enables us to give the appointment time to another patient.

Appointments

Please call our office by noon on the business day (Monday - Friday) prior to your scheduled appointment to notify us if you need to reschedule or cancel the time that was reserved for you. Appointments which are rescheduled or cancelled without advanced notice will be subject to a **$50 Late Cancellation Fee**. This fee will not be submitted to insurance. It is your responsibility and must be paid in full prior to scheduling your next appointment.

Deposits may be required prior to rescheduling a new date and time. This deposit is applied to the cost of the procedure or your visit. If the deposit is not needed toward the cost, and you keep your appointment, you will receive a refund. If you fail to keep the appointment, no refund will be given. Patients who reschedule multiple times may see limitations to access future appointments.

No Shows
Patients who do not show up for their appointment without a call to cancel are considered a No Show and will be subject to a **$75 No Show fee**. This fee will not be submitted to insurance. It is your responsibility and must be paid in full prior to scheduling your next appointment. Patients who No Show three (3) times may see limitations to access future appointments.

Patient Signature: _____ Date: _____

Photography Waiver and Consent

I, _____, do hereby authorize and consent to the use of photographs, video recordings and x-rays of me taken by Dr. Alfredo Brest Vico. I also grant permission to reproduce, print, publish, and/or distribute these images for use in articles, lectures, or advertisements to promote cosmetic dentistry. I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record. I do not expect compensation, financial or otherwise, for the use of these images.

Please initial:

_____I consent to the use of my photographs and/or videotape for articles, lectures, marketing, advertising, and laboratory use.

_____I consent to the use of my photographs and/or videotape ONLY for laboratory use.

_____I consent to the use of photographs and/or videotape EXCEPT those showing full face or identifying views

_____I DO NOT consent to the use of my photographs or videotape.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization. Unless revoked by me, this authorization expires 10 years from the date I sign below.

Patient Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

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

Patient Signature: _____ Date: _____

Acknowledgement of Receipt of Dental Materials Fact Sheets

You may refuse to sign this acknowledgement.

I, _____, have received a copy of the Dental Board of California's Dental Materials Facts.

Patient Signature: _____ Date: _____