# BRANDON TREVIÑO, D.D.S.
Cosmetic & Family Dentistry

## Patient Information

Patient Name:______________________________________________ Date:______________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Other________________

Social Security #:______________ Birth Date:______________ Driver's License:________________

Phone (Home):________________ (Work):____________________ (Cell):__________________

Email:__________________________________________ Fax:_________________________

Address:______________________________________________________________________
Street Apt #

______________________________________________________________________
City State Zip Code

## Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another Doctor ☐ Insurance

☐ School ☐ Work ☐ Internet ☐ Welcome Wagon ☐ Advertisement ☐ Other ______________

Name of person/office referring you:_____________________________________________________

## Responsible Party Information

Name:________________________________________________________________________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Other________________

Social Security #:______________ Birth Date:______________ Driver's License:________________

Phone (Home):________________ (Work):____________________ (Cell):__________________

Email:__________________________________________ Fax:_________________________

Address:______________________________________________________________________
Street Apt #

______________________________________________________________________
City State Zip Code

## Employment Information

The following is for: ☐ Patient ☐ Person responsible for the account

Employer's Name:______________________________________ Occupation:________________________

Address:________________________________________________________________

Street Apt #

________________________________________________________________

City State Zip Code

## Insurance Information

Name:________________________________________ Is the Insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _______________ Social Security #:____________________ Group#:___________

Insured's Address:______________________________________________________________

Street Apt #

________________________________________________________________

City State Zip Code

Insured Employer Name:____________________________________________________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:______________

Insurance Plan Name:_______________________________ Insurance Phone:_____________________

## Emergency Contact Information

Who should we contact in case of an emergency: ____________________________________________

Relationship to patient:__________________________

Emergency Contact Phone #:______________________

Patient's Physician's Name:____________________________

Physician Phone #: _________________________________

# Medical History

OFFICE USE ONLY
RMH:
ALERT: ☐ Yes ☐ No

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
If yes, for what?_______________

Have you ever taken prescription medications for weight loss? ☐ Yes ☐ No
If yes, did you take any of the following:
☐ Yes ☐ No Fen-Phen (Fenfluramine-Phenpermine)
☐ Yes ☐ No Pondimen (Fenfluramine)
☐ Yes ☐ No Redux (Dexfenfluramine)
If yes to any of the above, did you have a medical exam for heart disease? ☐ Yes ☐ No

Are you aware of having an allergic (or adverse) reaction to any medication or substance? ☐ Yes ☐ No
If yes, please list:_______________

Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No
If yes, for what?_______________

Are you taking any medications, drugs, or pills now? ☐ Yes ☐ No
Please list:_______________

*WOMEN:* Are you Pregnant or Trying to Get Pregnant? ☐ Yes: Months?_______ ☐ No
Nursing? ☐ Yes ☐ No
Taking Birth Control Pills? ☐ Yes ☐ No

| Condition | | Condition | |
|---|---|---|---|
| Heart (surgery, disease, attack) | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No |
| Chest Pain | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No |
| Congenital Heart Disease | ☐ Yes ☐ No | Contact Lenses | ☐ Yes ☐ No |
| Heart Murmur | ☐ Yes ☐ No | Emphysema/Bronchitis | ☐ Yes ☐ No |
| High Blood Pressure | ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No |
| Low Blood Pressure | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Artificial Heart Valve | ☐ Yes ☐ No | Asthma | ☐ Yes ☐ No |
| Stents, Rods, Pins Ever Placed | ☐ Yes ☐ No | Hay Fever | ☐ Yes ☐ No |
| Rheumatic Fever | ☐ Yes ☐ No | Latex Sensitivity | ☐ Yes ☐ No |
| Arthritis/Rheumatism | ☐ Yes ☐ No | Seasonal allergies/Hives | ☐ Yes ☐ No |
| Cortisone Medicine | ☐ Yes ☐ No | Sinus Trouble | ☐ Yes ☐ No |
| Stroke | ☐ Yes ☐ No | Radiation Therapy | ☐ Yes ☐ No |
| Artificial Joints (Hip, knee, etc) | ☐ Yes ☐ No | Chemotherapy | ☐ Yes ☐ No |
| Kidney disease/dialysis | ☐ Yes ☐ No | Cancer | ☐ Yes ☐ No |
| Hepatitis (Type: ____) | ☐ Yes ☐ No | Venereal Disease | ☐ Yes ☐ No |
| AIDS/HIV Positive | ☐ Yes ☐ No | Blood Transfusion | ☐ Yes ☐ No |
| Cold Sores/Fever Blisters | ☐ Yes ☐ No | Liver disease | ☐ Yes ☐ No |
| Hemophilia | ☐ Yes ☐ No | Neurological Disorder | ☐ Yes ☐ No |
| Bruise/bleed easily | ☐ Yes ☐ No | Fainting/Dizzy Spells | ☐ Yes ☐ No |
| Epilepsy/Seizures | ☐ Yes ☐ No | Psychiatric/Psychological | ☐ Yes ☐ No |
| Ulcers | ☐ Yes ☐ No | Substance Abuse | ☐ Yes ☐ No |
| Diabetes (Type: ____) | ☐ Yes ☐ No | Heart Pacemaker | ☐ Yes ☐ No |

Do you have or have had any disease, condition, or problem not listed? ☐ Yes ☐ No
If yes, please list:_______________

**I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to contact my respective health care provider or agency, which may release such information to you. I will notify the doctor of changes in my health or medication.**

Patient/Guardian Signature_______________ Date:_______________

# Dental Health History

What is the reason for your visit today?______________________________

______________________________

Date of Last Dental Visit:________ Date of Last Cleaning:________ Date of Last Full Mouth X-rays:________

What was done at your last dental visit? ______________________________

Have you ever taken antibiotics prior to a dental appointment? ☐ Yes ☐ No
If yes, please explain:______________________________

Previous Dentist's Name:______________________________
Address:______________________________ State:________ Zip:________
Phone #: ________________

How often do you brush your teeth? ________________ How often do you floss?________________
What other dental aids do you use (Sonicare, toothpick, Waterpik, Listerine, etc)?________________

______________________________

Do you have any dental problems now? ☐ Yes ☐ No
If yes, please describe:______________________________

______________________________

**Are any of your teeth sensitive to:**
Hot or Cold? ☐ Yes ☐ No
Sweets? ☐ Yes ☐ No
Biting or Chewing? ☐ Yes ☐ No

**Do you:**
Notice any mouth odors or bad taste? ☐ Yes ☐ No
Frequently get cold sores, blisters, or any other oral lesions? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No
Any gum disease in family members? ☐ Yes ☐ No
Are you missing any teeth? ☐ Yes ☐ No
Have you noticed any loose teeth? ☐ Yes ☐ No
Does food get caught between your teeth? ☐ Yes ☐ No
If yes, where?________________

**Do you:**
Clench or grind your teeth? ☐ Yes ☐ No
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Hold foreign objects with your teeth, such as pencils, fingernails, etc? ☐ Yes ☐ No
Breathe through mouth? ☐ Yes ☐ No
Have tired jaws, esp. in the morning? ☐ Yes ☐ No
Smoke/chew tobacco? ☐ Yes ☐ No
Snore frequently? ☐ Yes ☐ No

**Have you ever had:**
Orthodontic treatment? ☐ Yes ☐ No
Oral Surgery? ☐ Yes ☐ No
Periodontal Treatment? ☐ Yes ☐ No
Your teeth ground or the bite adjusted? ☐ Yes ☐ No
A nightguard or occlusal guard? ☐ Yes ☐ No
A serious injury to the mouth or head? ☐ Yes ☐ No
If yes, please describe, including cause: ________________

______________________________

**Have you noticed or experienced:**
Clicking or popping of the jaw? ☐ Yes ☐ No
Pain (joint, ear, side of face)? ☐ Yes ☐ No
Difficulty in opening/closing mouth? ☐ Yes ☐ No
Headaches or shoulder aches? ☐ Yes ☐ No

Satisfied with the appearance of your teeth? ☐ Yes ☐ No
Is keeping all of your teeth important? ☐ Yes ☐ No
Do you feel nervous about treatment? ☐ Yes ☐ No
If yes, what is your biggest concern?________________

______________________________

Ever had an upsetting dental experience? ☐ Yes ☐ No
If yes, describe: ________________

______________________________

______________________________

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No
If yes, please describe:______________________________

______________________________

# Smile Evaluation

Patient Name:_______________________________________________ Date:__________________

We would like to help you obtain the smile you have always wanted. Please take a few minutes to complete this short Smile Evaluation. While using a mirror or looking at a photograph, please observe your teeth carefully. If you answer "No" to any of the questions below, please explain.

1. Are you pleased with the appearance of your teeth when you smile? ☐ Yes ☐ No

_______________________________________________________________________________

2. Do you have any concerns about bad breath? ☐ Yes ☐ No

_______________________________________________________________________________

3. Are there spaces between your teeth that you do not like? ☐ Yes ☐ No

_______________________________________________________________________________

4. Are you pleased with the shape of your teeth? ☐ Yes ☐ No

_______________________________________________________________________________

5. Are you pleased with the color of your teeth? ☐ Yes ☐ No

_______________________________________________________________________________

6. Are your teeth:

Chipped? ☐ Yes ☐ No
Sticking out too far? ☐ Yes ☐ No
Hidden? ☐ Yes ☐ No
Crowded? ☐ Yes ☐ No

7. Do you like the way your teeth fit together when you bite? ☐ Yes ☐ No

_______________________________________________________________________________

8. Are there old fillings or dental treatment that you are not happy with? ☐ Yes ☐ No

_______________________________________________________________________________

9. If anything, what would you change about your smile?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

10. Would you like to know how your smile could look different? ☐ Yes ☐ No

# Dental Information & Consent Form

Patient Name:_____________________________________________ Date:________________

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) ______________________’s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended and agreed upon treatment, and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I understand that Brandon Treviño, DDS, PA, cannot guarantee any estimated dental coverage. I understand that insurance is a contract between my insurance company and me. Brandon Treviño, DDS, PA, is NOT a party to this contract, in most cases. Brandon Treviño, DDS, PA, will bill your primary insurance company as a courtesy for patients. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of eligibility. I agree to pay any portion of the charges not covered by insurance. If my insurance company requires a referral and/or pre-authorization, I am responsible for obtaining it. Failure to obtain the referral and or/pre-authorization may result in a lower payment from the insurance company. If for some reason my insurance has not paid their portion within 60 days from the start of treatment, I am responsible for payment at that time. Finance charges will be assessed on accounts over 90 days.

5. FOR YOUR INFORMATION

   *FIXED OR REMOVEABLE PROSTHETICS*, such as dentures, crowns, bridges, or partial dentures, are understood to be uniquely suited to each particular patient. The full amount contracted for such services is, therefore, considered to be due and payable when the initial impression is made.

   *AS A COURTESY TO YOU*, Brandon Treviño, DDS, PA, will, if necessary, accept 50% of this amount at the time of the impression. The balance must be paid at the time of permanent seating, or no more than 30 DAYS from date of impression, whichever comes first, unless prior arrangements have been made with our Office Manager. We accept insurance for payment; however, you must pay your portion at the time services are rendered.

   *PROSTHETICS MUST BE SEATED IN A TIMELY MANNER TO INSURE YOUR COMFORT AND PROPER FIT*. If you fail to have your prosthesis seated within 60 days from the date of impression, and a second impression must be made, you will be charged an additional amount of one-half of our current charge of such procedure.

   *WE OFFER YOU QUALITY DENTAL CARE, ECONOMICALLY PRICED*, and we want you to feel comfortable with all of our treatments and policies. Please feel welcome to contact out office manager with any questions that you may have.

**Health Information**
I understand to disclose all previous illnesses, medical and dental history, including all medications. Undisclosed medical information and current medication, allergies, or illnesses are risk factors. I agree to allow the use of my information only where it is necessary for treatment or to process insurance claims.

**Drugs, Latex, and Medication**
I understand that antibiotics and other medications can cause allergic reactions and/or anaphylaxis, which is a potentially life threatening condition that can interfere with normal breathing. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine, which is used in some dental injections, increases heartbeat, and depending on my health status, may be dangerous.

**Needle Stick**
If a staff member is inadvertently stuck with a needle or sharp instrument used on me, I consent to have my blood drawn for analysis in a timely manner.

**Fillings, Crowns, and Unanticipated Root Canals**
It is possible that a tooth will require a root canal, even after a simple filling or crown is done. Sometimes this cannot be foreseen.

**Root Canal Failure**
Root canals can fail and may require additional treatment or require extraction (removal) of the tooth.

**Porcelain Crowns, Veneers, Bonding, and Cosmetic Fillings**
Once a crown, veneer, bonding, or filling is placed, I understand the color cannot be changed without a remake and that they can chip or break, just like real teeth. I have been counseled, informed, and educated on how it is important to maintain a balanced bite. I know that this may be complicated due to stress, clenching, grinding, and genetics. I am aware that most people grind their teeth subconsciously, which is damaging and can break teeth or dental restorations. I have been informed about the need to wear an occlusal splint for protection.

**Gum Treatment vs. "Just a Cleaning"**
If I do not maintain proper oral hygiene or proper professional care, I can expect to have a deteriorating gum condition called periodontal disease. I am aware that periodontal disease requires more treatment than a simple cleaning.

**Extractions and Surgery**
I understand that all tooth extractions or dental surgeries carry risks. Some are minor, like a dry socket following an extraction. Some could be life threatening, such as post-surgical infection or anaphylaxis.

**Fee for Additional Care or Specialty Care**
I understand that I may need treatment beyond what is originally planned (e.g. a crowned tooth may still need a root canal and may be referred to a specialist for additional care.)

**Limitation of Insurance Coverage**
Often there are changes beyond what insurance will pay, (e.g. sterilization fee, nitrous oxide, temporary dentures, bleaching, or cosmetic work). Also, as a service to our patients, this office will file insurance claims on their behalf; however, understand that what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what my insurance does not cover and/or if my insurance does not pay within 60 days.

**24-Hour Notice of Cancellation**
I agree to give *24-business* hours notice of cancellation or I will pay a broken appointment fee which is a percentage of your scheduled treatment.

**Requesting Record Transfer**
Professional courtesies occur between dental offices. I understand that my dental records will be sent directly to the other dental office only after a written consent form is received. I understand there is a $25 fee to have my records copied and released.

**Hygiene Appointments**
If I am more than 15 minutes late for my cleaning appointment, I will either accept what appointment time is left, or will reschedule and pay the broken appointment fee.

**Appointment Times and Emergency Care**
It is our office policy and philosophy to be readily available for any patient in discomfort, or in an emergency situation. This courtesy is extended to all patients, and we ask for understanding when these unexpected situations arise. Out of respect for your time, we will keep you informed of such instances. We thank you, in advance, for your patience.

**My signature below confirms that I have read, acknowledged, and agreed to the all the above. All of my questions have been answered fully.**

Patient's signature:_____________________________ Date:____________ Witness:____________________

Parent/Guardian:_______________________________ Relationship to Patient:_____________________

# Notice of Privacy Policies

**This notice describes how your medical information may be used, disclosed, and how you can get access to this information.**

**<u>Please review the following carefully.</u>**

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or assist with, aid in, or facilitate the collection of data for purpose of utilization review, quality assurance, or medical outcomes for evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, managed care organizations, IPAs, Medicare/Medicaid, other governmental or third party payors, or any organizations contracting with any of the above or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical or financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Policies and to abide by its terms. We reserve the right to change our privacy policies and apply revised privacy policies to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Policies is effective immediately.

Patient/Parent or Guardian Signature___________________________________Date_____________________

# Explanation of Late Charges & Finance Charges

**LATE CHARGE:** If your minimum payment is not received by the due date, you may be assessed a late payment charge. The amount of the late charge to be assessed is the maximum amount authorized under the laws of the state of your domicile. In most states, the late charge will be $5.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $20.00.

**FINANCE CHARGE: A** finance charge is imposed on those charges not paid in full within 30/60/90/120/150 days of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown below on the front of your billing statement. The finance charge is a periodic rate of 1.25% per month. (An annual percentage rate of 15%). The finance charge is computed by multiplying the balance on which the finance charge is computed by the periodic rate shown above. There is a $1.00 minimum finance charge

**YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT**

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights.

In your letter, please include the following information:

• Your name and account number.

• The dollar amount of the suspected error.

• Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are not sure about.

**YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE**

• We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.

• After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.

• If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn’t make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.

• If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill. And we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
• If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
• Your continued use of this account constitutes your acceptance of the above stated conditions.

________________________________ Signature

__________________ Date

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

I hereby authorize payment of the dental benefits otherwise payable to me directly to Brandon Treviño, DDS, PA.

A photocopy of this document may act as an original.

________________________________ Signature of Insured

______________________ Today's Date