



EAST ORLANDO
DENTAL
Dr. Karim Morales, DMD

Building *Better* Smiles.

Patient Registration

First Name: _____

Last Name: _____

Preferred Name: _____

Patient is: Policy Holder Responsible Party

Birth Date: _____ Age: _____ Soc.Sec.: _____ Driver's Lic: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Secondary Phone: _____ Email: _____

Yes, I'd like to receive correspondences via email.

Sex: Male Female

Martial Status: Married Single Divorced Separated Widowed

Insurance

First Name: _____

Relationship to insured: Self Spouse Child Other

Soc.Sec.: _____

Birth Date: _____

Employer: _____

Insurance Company: _____

Address: _____

Address: _____

City, state, zip: _____

City, state, zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

How did you hear about us?

Please check all that apply:

INTERNET:

Internet Search: Google Bing Yahoo Yelp City Search RateADentist

Digital Coupons: LivingSocial Groupon Social Media: Facebook Twitter Instagram Google+

MAIL: Postcard Best Community Value coupons ValPak coupons

REFERRAL (name): _____

OTHER (specify billboard, publication, event, etc): _____

Additional Comments?

*Don't forget to review us for a chance at a FREE GIFT! www.eastorlandodental.com/testimonials.htm
Ask a staff member for details on how we hear your voice!

Proceed to
medical history 



**EAST ORLANDO
DENTAL**

Medical History

Building *Better* Smiles.

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No _____

Do you use controlled substances? Yes No _____

Women: Are you

Pregnant/Trying to get pregnant? Yes No

Taking oral contraceptives? Yes No

Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Veneral Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No _____

Comments:

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 _____



Building *Better* Smiles.

EAST ORLANDO
DENTAL

Confidential Consent

Date _____ SS/HIC/Patient ID# _____

Patient Name _____ Date of Birth _____

Please read and initial the items checked below. Then read and sign the section at the bottom of form.

1. Work to be Done

I understand that I am having the following work done: Fillings _____ Bridges _____ Crowns _____ Extractions _____
Impacted teeth removed _____ General Anesthesia _____ Root Canals _____ Other _____
(Initials _____)

2. Drugs and Medications

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
(Initials _____)

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.
(Initials _____)

4. Removal of Teeth

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
(Initials _____)

5. Crown, Bridges and Caps

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.
(Initials _____)

6. Dentures, Complete or Partial

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
(Initials _____)

7. Endodontic Treatment (Root Canal)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
(Initials _____)

8. Periodontal Loss (Tissue & Bone)

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.
(Initials _____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient



EAST ORLANDO
DENTAL

Building *Better* Smiles.

Notice of Privacy Practices Acknowledgement

East Orlando Dental
11780 E. colonial Drive
Orlando, Fl. 32817
407-282-2101

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- o Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- o Obtain payment from third-party payers
- o Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: X _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason



EAST ORLANDO
DENTAL

Building *Better* Smiles.

East Orlando Dental

Financial Policy

Welcome to East Orlando Dental! It is important that you, as a new patient, understand our financial policy. This is a very important document; please take the time to carefully read over the policy before signing.

It is expected that patients pay in full with cash, credit or debit prior to services rendered unless specific arrangements are made in advance. We DO NOT accept checks. We have a variety of flexible payment options available to you that may be able help alleviate any financial concerns you may have concerning your treatment plan.

For those patients with insurance, we want to help you better understand your coverage. First, we would like to clarify a common misconception concerning dental insurance; dental insurance was not designed to cover ALL of your dental treatment expenses. In fact, most plans have coverage limits and/or various degrees of co-payment requirements. Most dental plans DO NOT cover 100% of the cost of treatment.

All levels of coverage, including allowed fees, are governed by the premiums paid by the policyholder and/or employer contracts. We strive to gather as much information as possible on your specific policy from the insurance company; however, the information given by the insurance company is not a guarantee of payment and is subject to the insurance company's review. Therefore, we will estimate cost as closely as possible to your insurance company's coverage for treatment, but until we actually receive payment from the insurance company, it will remain an ***estimate of coverage only***.

Your human resources department can also help you better understand your specific policy and your employer's contract with the insurance company. Please remember, dental insurance is a contract between the insurance company, your employer, and you, the patient, who holds the final financial responsibility.

Please be advised when taking advantage of one of our coupons or special offers, the x-rays are provided as a complimentary service, therefore, if you need copies of the x-rays, they will be charged to you at the regular fee schedule as followed:

D0210-\$125.00, D0274-\$60.00, D0220-\$26.00, D0230-\$23.00

Cancellation Policy: We know emergencies arise. Please give us ***at least 24 hours'*** notice to cancel/reschedule an appointment to avoid a \$75.00 cancellation fee. Thank you!

Patient Signature

Date

Patient Photo Release Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. This release is strictly designated to give permission to Dr. Karim Morales DMD, to use my digital patient photos. I will allow these photos to be shared with other professionals, patients and public in an educational, advertising, and social media setting. Dr. Morales will have permission to use these photos in the manner described above unless I request him to no longer use them. A written request form is available to do so. I understand that by allowing Dr. Morales to use my photos, he is able to share "before and after" images to educate, inform, advise, promote and explain procedures and possible results of treatment. I understand that I have the option to decline this request, and am not obligated in any way to provide permission to use these photos. I will allow Dr. Karim Morales, DMD. to share my digital patient photos with other patients and/or professionals in an educational, advertising, and social media setting.

Full Facial Photos

Close Up Photos Only (no full face)

Patient Name _____

Signature _____

Date _____

I am requesting that my digital patient photos not be shared with other professionals, patients, or public.

Patient Name _____

Signature _____

Date _____