Dr. Gina Cozzarelli DMD
Dr. Osmil Reyes Canals DDS

Please Complete all information that applies to you - Thank You!

PATIENT NAME :________________________________ Date of Birth :_____/_____/______

NAME LAST NAME MIDDLE INITITAL

☐ Single ☐ Married ☐ Divorced ☐ Male ☐ Female

Address_________________________________ City________________________State______ Zip _____________

HomePhone: ______________________ Work:_________________________ Cell: ________________________

E-mail: ____

Employer:____ Occupation:____________________________

Soc Sec No._________-_________-_____________ Dental Insurance Co:___________________________________

Dental Id No.____________________________________ Group No.____________________________________

Is the patient covered by another Insurance? Y N Dental Insurance Co:_________________________________

How did ou hear about us? Google? Friend ? Church? Network ? ** Whom may we Thank for your referral?

HUSBAND, FATHER OR RESPONSIBLE PARTY

Last Name___________________________________First______________________Initial_________

Address__________________________________ City______________________State______ Zip _____________

Home Phone: _______________________ Work:________________________ Cell: _________________________

E-mail: ____

Employer:____ Occupation:________________________________

Soc Sec No._________-________-____________ Dental Insurance Co:_____________________________________

Dental Id No.____________________________________ Group No.________________________________

WIFE, MOTHER OR RESPONSIBLE PARTY

Last Name___________________________________First______________________Initial_________

Address__________________________________ City______________________State______ Zip _____________

Home Phone: _______________________ Work:__________________________ Cell: _________________________

E-mail: ____

Employer:____ Occupation:________________________________

Soc Sec No._________-________-____________ Dental Insurance Co:_____________________________________

Dental Id No.____________________________________ Group No.________________________________

NEAREST RELATIVE

Last Name___________________________________First______________________Initial_________

Address__________________________________ City______________________State______ Zip _____________

Home Phone: _______________________ Work:_________________________ Cell: _________________________

AUTHORIZATION:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my(or my child's) health care, advice, and treatment provide for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my(my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill of services. **I understand I am financialy responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer. I authorize Ortho Smiles to request **Pre-Treatment Estimates** for the purposes of better understanding my coverages percentages, co-payments and Insurance maximum allowances.

I attest to the accuracy of the information on this page.

Signature **X**____ Date________________________

PATIENT REGISTRATION

SECTION A: PATIENT GIVING CONSENT

Patient Name: ____

Address: ____

Telephone No. ____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWIG SATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have he right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations of the uses and disclousures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of privacy Practice which will contain the changes. Those changes may apply to any of your protected health information that we mantain.

You may obtain a copy of our Notice of Privacy Practices including any revisions of our Notice a any time by contacting:

Compliane Officer:	**Margaret Jorge**
Telephone:	**954-404-6712**
Address:	**302 NW 179TH Ave. Suite 201A Pembroke Pines FL 33029**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed Above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, ______your name____ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices . I understand that by signing this Consent I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment acivities and health care operations.

Signature: **X**____Date:_____________________________

If this Consent is signed by a personal representative(parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name:_________________________________Relationship to the patient: ____________________

SECTION D: OFFICE USE ONLY

We atempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergencysituation prevented us from obtaining acknowledgement
- ☐ Other(Please Specify)

Office Representative's Signature: _______________________________________Date:_________________________

PRIVACY PRACTICES RECEIPT/CONSENT FORM

PLEASE COMPLETE ALL INFORMATION-THANK YOU!

PATIENT NAME:________________________________Date of Birth :________________

DENTAL HISTORY

Reason for today's visit:______________________________Date of last Dental Visit: ______________________

Former Dentist:___________________________________Date of last Dental X-Rays:_______________________

Please check with √ if you have/had:

Bad Breath	☐	Lip or Cheek bitting	☐	Have you ever had an allergic reaction to Novocaine, local or general anesthetiscs?	☐
Blisters on lips or mouth	☐	Loose teeth or broken filling	☐	If Yes, Please explain :________________	
Burning sensation on tongue	☐	Mouth breathing	☐	_______________________________________	
Chew on one side of mouth	☐	Sinus Trouble	☐	Have you had trouble from previous dental care?	☐
Cigarette, pipe or Cigar smoking	☐	Orthodontic Treatment	☐		
Smokeless tobacco	☐	Nitrous Oxide	☐	If Yes, Please explain :________________	
Dry mouth	☐	Tonsilitis	☐	_______________________________________	
Periodontal treatment	☐	Cold, heat, sweets	☐	Food collection between teeth	☐
Clench teeth	☐	Are you happy with your smile?		Growths or sore spots in mouth	☐
Grind teeth	☐	______________________________		Gums swollen,tender,or bleeding	☐
How often do you floss? ___________		How often do you brush? __________		Sensitivity to pressure or irritants	☐
				Head, Neck,or jaw pain or aches	☐

MEDICAL HISTORY

Do you have or have you had any of the followings? (**Mark with a √ Yes or No**)

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Excessive Bleeding	☐	☐	Low Blood Pressure	☐	☐
Alzheimer's Disease	☐	☐	Excessive Thirst	☐	☐	Lung Disease	☐	☐
Anaphylaxis	☐	☐	Faiting Spells/ Dizziness	☐	☐	Mitral Valve Prolapse	☐	☐
Anemia	☐	☐	Frequent Cough	☐	☐	Osteoporosis	☐	☐
Angina	☐	☐	Frequent Diarrhea	☐	☐	Osteopnia	☐	☐
Arthritis/Gout	☐	☐	Frequent Headaches	☐	☐	Parathyroid Disease	☐	☐
Artificial Heart Valve	☐	☐	Genital Herpes	☐	☐	Psychiatric Care	☐	☐
Artificial Joint	☐	☐	Glaucoma	☐	☐	Radiation Treatments	☐	☐
Asthma	☐	☐	Hay Fever	☐	☐	Recent Weight Loss	☐	☐
Blood Disease	☐	☐	Heart Attack/Failure	☐	☐	Renal Dialysis	☐	☐
Blood Transfusion	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever	☐	☐
Breathing Problems	☐	☐	Pacemaker	☐	☐	Rheumatism	☐	☐
Bruise easily	☐	☐	Heart Trouble/Disease	☐	☐	Scarlet Fever	☐	☐
Cancer	☐	☐	Hemophillia	☐	☐	Shingles	☐	☐
Chemotheraphy	☐	☐	Hepatitis A	☐	☐	Sickle Cell Disease	☐	☐
Chest pains	☐	☐	Hepatitis _B or _C	☐	☐	Sweling of Feets / Ankles	☐	☐
Cold Sores/Fever Blisters	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Congenital heart Disorder	☐	☐	High Blood Pressure	☐	☐	Intestinal Disease	☐	☐
Convulsions	☐	☐	High Cholesterol	☐	☐	Stroke	☐	☐
Cortisone	☐	☐	Hives or Rash	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Hypoglycemia	☐	☐	Tuberculosis	☐	☐
Drug Addiction	☐	☐	Irregular Heartbeat	☐	☐	Tumors/Growths	☐	☐
Easily Winded	☐	☐	Kidney Problems	☐	☐	Ulcers	☐	☐
Emphysema	☐	☐	Leukemia	☐	☐	Venereal Disease	☐	☐
Epilepsy or Seizures	☐	☐	Liver Disease	☐	☐	Yellow Jaundice	☐	☐

Have you ever had any serious illness not listed? Y / N If yes, Explain ____

DENTAL & MEDICAL HISTORY

PLEASE COMPLETE ALLL INFORMATION-THANK YOU!

PATIENT NAME:____

MEDICAL HISTORY Continue

Physician's name:____ Date of last visit:_____________________

Have you ever been hospitalized or had a major operation? Y / N If yes, Explain ____

Have you ever had a serious head or neck injury ? Y / N If yes, Explain ____

Do you take or have you taken Phen-Fen or Redux? Y / N If yes, Explain ____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y / N If yes, Explain

Pregnant? ☐ Trying to get Pregnant? ☐ Nursing? ☐ Taking oral Contraceptives? ☐

ALLERGIES

Allergic to any of the following?

	Yes	No		Yes	No
Acrylic	☐	☐		☐	☐
Latex	☐	☐		☐	☐
Metal	☐	☐	Local Anesthetics	☐	☐
Codeine	☐	☐	Aspirin	☐	☐
Other	☐	☐	If Yes, Explain ____________________________		

Are you taking Medications, pills or drugs? Y / N If yes, Please List them: ______________________________

____

Do you use controlled substances? Y / N If yes, Please List them: ______________________________

____

How old is the Denture/Partial denture you are wearing? __________________

OFFICE USE ONLY

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of knowledge.

Patient/ Guardian Signature: X____Date:_______________________

Reviewed by: ____Date:_______________________

PATIENT NAME:____DATE:____________________

Ortho Smiles P.A. is commited in providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your responsability.

- **ALL PATIENTS MUST COMPLETE OUR" PATITENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE .**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD,DISCOVER AND CARE CREDIT.**
- **WE PROVIDE INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

ADULT PATIENTS

Adult patiens are responsible for full payment a time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents are responsible for full payment at time of service.

UNCCOMPANIED MINORS

The parents or guardians are responsible. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved treatment plan or Visa, Master Card or Discover.

INSURANCE

We provide insurance company billing as a *courtesy* to our patients. The patient portion of particular dental service(s)is estimaed and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In adition certain insurance companies have annual limitaion for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year you will be responsible for the full amount of denta services that exceed the particular plan's limitations. The patient is responsible for monitorig the amont of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provide by Ortho Smiles staff regarding his/her remaining benefit in any such benefits period.

The claims we submit to insurance companies indicate tha you have assined those benefits to Ortho Smiles PA however, if you are paid by the insurance company instead of Ortho Smiles PA, you then become responsible for the total account balance and pament would be expected immediatly.

If you or your family has more than one dental insurance program, we will assit you in obtaning the maximum benefits available.

DELINQUENTS PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition all payments returned due to non-sufficient funds will be subject to a **NSF fee of $25.00**

MISSED APPOINTMENTS

Unless cancelled at least *24 hours* in advance, our policy is to charge for **missed appointments at the rate of $25.00 per each 60 minutes of missed appointment time.** Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Finacial Policy. Please let us know if you have any questions or

Responsible Party Signature: X____Date:____________________

FINANCIAL POLICY

PATIENT NAME:____DOB:_______________________

I agree that the practice of Ortho Smiles, P.A. may communicate with me electronically through the following electronic means: Please proveide those who apply.

- ☐ Email:____
- ☐ Text on my Cellphone:____
- ☐ Fax:____

I am aware that the there is some level of risk that third parties might be able to read unencrypted faxes, emails and texts and I am responsible for providing the practice of Ortho Smiles, P.A. any updates to my email address, cellular and fax numbers, and/or to indicate any restrictions.

I understand that I can withdraw or limit my consent to any of the above means of electronic communication by giving us written notice of your revocation submitted to the Contact Person listed Above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

Signature: X____Date:__________________________

Please send my prescriptions to:

Pharmacy Name: ____

Address: ____

____

Phone: ____________________________________

concerns.