

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____

Last Name: _____

Middle Initial: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Birth Date: _____

Soc Sec: _____

Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient

☐ Primary Insurance Policy Holder

☐ Secondary Insurance Policy Holder

Patient Information

Address: _____

Address 2: _____

City: _____

State / Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____

Age: _____

Soc Sec: _____

Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Patient Signature: _____

Date: _____

MEDICAL HISTORY

Patient Name: _____ Nickname: _____ Age: _____

Name of Physician/and their specialty: _____ Phone #: _____

Most recent physical examination: _____ Purpose: _____

What is your estimate of your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

DO YOU HAVE or HAVE YOU EVER HAD

	YES	NO		YES	NO
1. Hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	27. Osteoporosis/Osteopenia _____	<input type="checkbox"/>	<input type="checkbox"/>
2. An allergic reaction to: (Circle) _____	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you been treated w/ Bisphosphonate drug's? (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin			(Fosamax®, Aredia®, Zometa®, Actonel®, Boniva, RANKL, Denosumab, Prolia)		
Ibuprofen			P 29. Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Acetaminophen			30. Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Codeine			31. Contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin			32. Head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin			33. Epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
Tetracycline			34. Neurologic problems (attention deficit disorder) _____	<input type="checkbox"/>	<input type="checkbox"/>
Sulpha			35. Viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetic			36. Any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
Clindamycin			37. Hives, skin rash, hay fever(circle) _____	<input type="checkbox"/>	<input type="checkbox"/>
Flouride			38. Venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Metals (nickel, gold, silver)			39. Hepatitis (type ____) _____	<input type="checkbox"/>	<input type="checkbox"/>
Clindamycin			40. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Valuim or other sedatives			41. Tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
Latex			B 42. Radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any of these Medications? (Circle) _____	<input type="checkbox"/>	<input type="checkbox"/>	B 43. Chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
Tagamet® (cimetidine)			P 44. Emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Prilosec® (omeprazole)			45. Psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
Cardizem® (diltiazem)			B 46. Antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Calan, Isonit® (Verapamil)			BP 47. Alcohol, Drug dependency (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>
Pre-medication before dental treatment			48. Please provide current weight: _____		
Serzone® (nefazodone)			ARE YOU:		
Dilantin® Tegretol			49. Presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates (any)			50. Aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>
Biacin® (clarithromycin)			51. Taking medication for weight management (fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
St. John's Wort, Kava-Kava			52. Taking dietary supplement _____	<input type="checkbox"/>	<input type="checkbox"/>
P 4. Heart problems or cardiac stent within the last six months	<input type="checkbox"/>	<input type="checkbox"/>	53. Often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
5. History of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	54. Subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Artificial heart valve, repaired heart defect _____	<input type="checkbox"/>	<input type="checkbox"/>	P 55. A smoker or smoked previously (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>
P 7. Pacemaker, implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	56. Considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Artificial replacement joints (Year?) _____	<input type="checkbox"/>	<input type="checkbox"/>	57. Often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	58. Consume grapefruit juice, grapefruits or grapefruit extract? _____	<input type="checkbox"/>	<input type="checkbox"/>
P 10. High or Low blood pressure (circle) Your normal BP= _____	<input type="checkbox"/>	<input type="checkbox"/>	59. MALE – prostate disorders: _____	<input type="checkbox"/>	<input type="checkbox"/>
11. A stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	60. FEMALE – Taking Birth Control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	61. FEMALE – Pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
13. Prolonged bleeding due to slight cut (INR>3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>			
14. Emphysema, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>			
15. Tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>			
16. Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>			
17. Breathing, Sleeping problems, Snoring, Sinus (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>			
18. Kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>			
19. Liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>			
20. Jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>			
21. Thyroid, Parathyroid disease (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>			
22. Hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>			
23. High cholesterol, taking statin drugs (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>			
P 24. Diabetes (HbA1c) _____	<input type="checkbox"/>	<input type="checkbox"/>			
B 25. Stomach, duodenal ulcer (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>			
B 26. Digestive disorders, Gastric/acid reflux _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken in the last two years

Drug	Dosage	Purpose	Drug	Dosage	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

URGENT CARE QUESTIONNAIRE

*In order for us to provide the best diagnosis and treatment possible, please answer all questions to the best of your ability.
Thank you.*

On a scale of 1-10 , how important is your dental health to you? (1="Not very important," 10="Extremely important.")	1-2-3-4-5-6-7-8-9-10			
On a scale of 1-10 , how would you rate your current dental health? (1="Very poor," 10="Excellent.")	1-2-3-4-5-6-7-8-9-10			
Who may we thank for referring you?	Years		Months	
When was your last dental visit?				
Area of concern (please circle):	Upper Right	Lower Right	Upper Left	Lower Left
What is your immediate or main concern?				

PERSONAL HISTORY

Are you fearful of dental treatment?	YES	NO
If "yes," how fearful on a scale of 1(somewhat) to 10 (extremely)?	1-2-3-4-5-6-7-8-9-10	
Have you ever had trouble getting numb, or reactions to local anesthetic?	YES	NO
Do you experience spontaneous pain (pain for no apparent cause or reason)?	YES	NO
On a scale 1-10, what is your current pain level? (1="Slightly sensitive," 10="Extremely painful.")	1-2-3-4-5-6-7-8-9-10	

GUM AND BONE

Have you ever been treated for gum disease or been told you have lost bone around your teeth?	YES	NO
Do your gums bleed or are they painful when brushing, flossing or eating?	YES	NO
Do you have swelling inside or outside of your mouth?	YES	NO

TOOTH STRUCTURE

Do your parents or siblings have "bad teeth"?	YES	NO
Does the amount of saliva in your mouth seem too little (dry mouth) or do you have difficulty swallowing food?	YES	NO
Are any teeth currently sensitive to hot, cold, biting, brushing or sweets (circle all that apply)?	YES	NO
Do you have a cracked filling, broken, chipped or cracked tooth (circle all that apply)?	YES	NO

BITE, CHEWING AND JAW JOINT

Do you have problems with your jaw joint: pain, sounds, limited opening, locking, popping (circle all that apply)?	YES	NO
Is today's problem affecting your ability to eat or chew normally?	YES	NO
Do you clench or grind your teeth?	YES	NO
Do you have problems sleeping (i.e. restlessness), wake up with pain, headache or an awareness of your teeth?	YES	NO
Do you or have you ever worn a bite appliance (Niteguard, Splint)?	YES	NO

SMILE CHARACTERISTICS

Have you felt unhappy, uncomfortable or self-conscious about the appearance of your teeth?	YES	NO
Is there anything about the appearance of your teeth that you would like to change?	YES	NO
If "yes," what would you like to change?		

Patient's Name: _____

Patient's Signature: _____

Date: _____

Doctor's Signature: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice	October 1, 2003
Phone Number	(559) 435-3113

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way."

Patient or Representative Name (Please Print)

Patient or Representative Signature

Date

☐ Patient refused to sign ☐ Patient was unable to sign because _____

Financial Interest Disclosure

Under California law, I (Dr. Mirelez) am required to inform you, that I have a financial interest in **Dental Imaging Solutions**, to which I may refer you for services. There may be other organizations from which you may obtain these services. Should I decide to refer you to **Dental Imaging Solutions**, you should know that there may be alternative locations to acquire similar requested services.

Acknowledgement of Publicity Materials

☐ **I authorize** the taking of clinical photographs and videos and their use for scientific, educational and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold Mirelez Wellness Dental harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

☐ **I do NOT authorize** Mirelez Wellness Dental to take or share photographs and/or videos.

Signature

Date

J. ART MIRELEZ JR., DDS, FICOI, FAGD

5492 N. PALM AVENUE • FRESNO, CA 93704 • PHONE: 559.435.3113 • FAX: 559.435.5785

EMAIL: DRMIRELEZ@MIRELEZDENTAL.COM • WEB: WWW.MIRELEZDENTAL.COM



Financial Policy

To maintain operations and prevent potential misunderstandings, we ask you to accept and adhere to the following financial policy for dental treatment for yourself or any family member:

PATIENTS WITH DENTAL INSURANCE:

We understand that dental insurance plays a role in helping defray some of the costs of dental care. However, we would like to share with you the following facts about dental insurance.

Dental insurance often will not pay for everything. It is meant only to assist in paying for your dental care. Dental insurance plans have no correlation to actual patients' needs. As such, many routine and necessary dental services are not covered, even though you may need those services. Our responsibility is to provide you with the best care and treatment to meet your needs, not to match your care to insurance plan limitations. Many plans pay much less than you might expect. The benefits your plan pays for are largely determined by how much your employer or you pay in premiums for the plan. We are happy to submit your claims and help you to receive the maximum benefits due to you, but please understand that **we do not accept responsibility for collecting an insurance claim, or negotiate disputed claims. You remain responsible for payment for unpaid services.**

OPTIONAL PAYMENT TERMS:

- **Discount for Cash (no insurance):** We also provide a **5%** discount for restorative dental services when paid with cash or check, ***orthodontic and cosmetic treatment excluded***
- **In-Office Complete Dental Plan:** The complete dental plan (VIP) includes two complimentary cleanings, all exams and x-rays within the plan year, and you will receive a **20%** discount for restorative dental services. (Please note that discount will differ if financing is utilized) ***orthodontic and cosmetic treatment excluded**
- **Term Loan:** By arrangement with *Care Credit* and *Sunbit*, we offer our patients an interest-free term loan with no down payment, no annual fee, and no prepayment penalty (subject to approval). You can complete the provided "Payment Plan Credit Application" or you can visit www.CareCredit.com or www.sunbit.com to see which plan works best for you. You can find additional information at www.Mirelezdental.com.

APPOINTMENT FEE:

For each appointment, a specific amount of time and material is reserved especially for you. We strongly encourage our patients to keep their appointments. If you must change your appointment, we require a **48 business hour notice. Appoint fees depend on appointment type:**

- **Hygiene appointments: \$100 per hour.**
- **Dr. Appointments: \$200 per hour.**
- **Sedation appointments: \$1000.00. (Sedation appointments REQUIRE 5 day advance notice.)**

CONFIRMATION POLICY: We routinely confirm appointments via phone and or text. If we are unable to reach you, we may remove your appointment from the schedule and ask you to reschedule

COLLECTION POLICY:

Payments are expected at the time services are rendered. We accept cash, checks, debit cards, and all major credit cards. You will be responsible for a \$75.00 bookkeeping fee if your account is assigned to a third party for collection. Should suit be commenced to enforce any of the terms of this agreement, you shall pay all attorney's fees and costs. The Court of jurisdiction shall be Fresno County. You hereby grant the right to verify employment or run a credit report to assess your ability to fulfill your financial obligation to this agreement. If communication by phone is necessary, you grant permission to the office, or our assigns, to contact you by phone. If you are unavailable, and a recording device is operable, a message may be left providing a name and phone number.

Patient Name (Please Print) _____

Patient Signature _____

Date _____