Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: ____________

E-mail Address: ____________

Name: ____________
Last First Mi Mr Mrs Ms Dr

I prefer to be called: ____________ ☐ M ☐ F ☐ Non-binary

Birthdate: ___/___/___ Age: ____ SS#: ____________

Home Address: ____________ Apt/Condo #

____
City State Zip

☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Hm #: (____) ____________ Cell / Other #: ____________

Wk #: (____) ____________ Ext: ____ DL #: ____________

Employer: ____________

Employer's Address: ____________

____
City State Zip

How long there? ________ Occupation: ____________

Where & when are best times to reach you? ____________

Whom may we Thank for referring you? ____________

Other family members seen by us: ____________

Previous / Present Dentist: ____________
(Please Circle)

Person Responsible for Account: ____________

2 SPOUSE INFORMATION

His / Her Name: ____________

Employer: ____________

Contact #: (____) ____________ Ext: ____ SS #: ____________

Birthdate: ___/___/___ DL #: ____________

Relative or Friend not living with you (for emergency).

His / Her Name: ____________ Relation: ____________

Contact #: (____) ____________

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ____________

Insurance Co. Address: ____________

____
City State Zip

Insurance Co. Phone #: (____) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ___/___/___ Insured's ID #: ____________

Insured's Employer: ____________

Employer's Address: ____________

____
City State Zip

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ____________

Insurance Co. Address: ____________

____
City State Zip

Insurance Co. Phone #: (____) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ___/___/___ Insured's ID #: ____________

Insured's Employer: ____________

Employer's Address: ____________

____
City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

____
Signature Date

Continued on Back

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ______

Phone #: (____) ______ Date of last visit: ______

Your current physical health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ______

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one: ______

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: ______

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding / Hemophilia
Y N AIDS
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Autism
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Covid-19
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack / Surgery
Y N Heart Murmur
Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Treatment
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

______

Have you received vaccination for Covid-19? ☐ Yes ☐ No

Type? ______ Date(s)? ______

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry/Metals
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs/materials that you are allergic to: ______

______

5 DENTAL HISTORY

Why have you come to the dentist today? ______

______

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? ______

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No Whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? ______

______

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

______
Signature Date

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: ______ Date: ______

Doctor's Comments: ______

______

______

______

______

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. ______

Patient Signature ______ Date ______

Dentist Signature ______ Date ______

Has there been any change in your health status since your last visit? Y N
If Yes, please explain. ______

Patient Signature ______ Date ______

Dentist Signature ______ Date ______

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1700 S. Dixie Hwy., Suite 103 Boca Raton, FL 33432
Telephone: (561) 368-4057 Fax: (561) 368-3405

WELCOME NEW PATIENTS!!!

We feel it is very important to you as a new patient to understand the standard of care in our dental office. Our practice will strive to provide you with the finest quality dental care. This practice is prevention oriented. We have observed over the years that patients with costly dental treatments have admitted to several years between dental visits, neglectful home care, and in some cases health problems have all played a part in their dental demise.

We feel it is important to treat patients on an individual basis according to their specific dental needs, however, all patients should understand that in order to maintain optimum dental health, either a full mouth series of x-rays or four bitewing x-rays will be taken one time per year.

Examinations and routine dental cleanings should be performed every six months on healthy patients. Patients that have been diagnosed with a periodontal condition (gum disease) or patients that have extensive build up (plaque and tartar) should have periodontal cleanings every 3 months.

We also feel it is extremely important to have periodontal charting done one time per year in order to manage gum tissue properly.

Children under 18 years of age need to be accompanied by a parent or a guardian for their appointment.

Our office has instituted a **$15.00** sterilization and bio-hazardous waste removal fee on each office visit. This is necessary to cover the increased cost of supplies and continued high standard of sterilization this office abides by. Whenever possible, disposable products are used for your protection. All other instruments and hand- pieces are heat sterilized after each use, and hazardous waste must be properly disposed of by state licensed companies.

If you have any questions regarding your treatment, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship.

Please indicate by signing that you have read & understood our office policies.

X ____

Print Name | Signature | Date

Written Financial Policy

Thank You for choosing Coello Dentistry. Our primary mission is to deliver the most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable as possible by offering several payment options.

Any co-payment, deductibles or coinsurances, fees for noncovered services, or outstanding balances must be paid at the time of service. You may choose to pay with cash, check, credit card or CareCredit on the day that the treatment is rendered. For treatment plans requiring multiple appointments, alternative payment arrangements may be provided.

Dental Insurance: Coello Dentistry is happy to work with your insurance provider. Insurance is a contract between you and your insurance company. Although we may estimate what your insurance may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. However, if payment is not received from your insurance within 60 days, then you are ultimately responsible for payment.

We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify what dental coverage is available on your policy. You as the policyholder are primarily responsible to verify benefits. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for noncovered services that may result.

Cancellation Policy: If you are unable to keep an appointment, please call the office to reschedule at least **24 hours** in advance. Patients with three missed appointments may be asked to transfer their records to another office. Patients who are more than 20 minutes late may be asked to reschedule. A broken appointment fee of $50 for hygiene and $125 with the Doctor will be charged to patients who miss or cancel an appointment without 24 hours notice. These fees are not covered by your insurance.

Returned Checks: Any fees charged by the bank for a returned check will become patients responsibility.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the Past Due Accounts balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Finance Charge: A finance charge will be imposed on your account balance which has not been paid within thirty (30) days of the time the item was added to the account. The finance charge will be computed by applying at an annual percentage rate of ten percent (10%) to the "overdue balance" of your account every month the balance is not paid. The minimum monthly finance charge is $10.

Past Due Accounts: If your account becomes past due over 120 days, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency you agree to pay our office a $50 collections fee and all of the collection of the balance to a lawyer, you agree to pay all the lawyer's fees which we incur, plus any court costs. You understand if this account is submitted to an attorney or collection agency, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Once you have signed this document you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

X

Print Name	Signature	Date

Authorization for Inter-Office Communication

For the patient, named below, I hereby authorize the office of Drs. Carlos, Karen, Ryan and Anthony Coello to release medical information, dental history, x-rays and any other health information that may be used for proper diagnosis and treatment to the specialist dentist or treating physician as needed to administer appropriate treatment/care.

Dental and health records may be mailed, e-mailed, faxed or electronically transmitted. I allow release of these records for proper treatment.

** Refusal to disclose all or some health care information may result in improper diagnosis or treatment, and/or denial of coverage for health benefits or other adverse consequences.

X

Print Name	Signature	Date

HIPAA Disclosure Form

May we identify ourselves over the phone? ☐Yes ☐No

May we leave messages? ☐Yes ☐No

I, the Patient, hereby authorize Coello Dentistry to discuss my protected health information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following individuals;

Name:__________________________ DOB:___________ Relationship:______________

Name:__________________________ DOB:___________ Relationship:______________

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor:____________________________________ Phone:________________________

Doctor:____________________________________ Phone:________________________

X ____

Print Name Signature Date