Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ____/____/____ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____)_____ SS #: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

2 General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

Other siblings: _____

Previous / Present Dentist: _____ Last Visit Date _____

Dentist's Phone #: (____) _____

Relative or Friend not living with you:

Name: _____ Phone: (____) _____

Address: _____
City State Zip

3 Parent's Information

Person Responsible for Account: _____ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (____) _____

_____

_____

SS #: _____ DL #: _____

Wk #: (____)_____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____) _____

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

☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (____) _____

_____

_____

SS #: _____ DL #: _____

Wk #: (____)_____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____) _____

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

4 Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of Parent or Guardian Date

Continued on Back

5 Dental History

Why did you bring the child to the dentist today? _____

_____

_____

Has your child ever been prescribed Fosamax or any other bisphosphonate? If yes, when? _____ ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking: _____

_____

Aside from items listed, please list all drugs/things that the child is allergic to:

_____

_____

Yes No Latex Yes No Metals/Nickel Yes No Plastic

6 Medical History

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Hearing Impairment
Y	N	ADD/ADHD	Y	N	Heart Murmur
Y	N	AIDS/HIV+	Y	N	Hepatitis
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Any Hospital Stays/Operations?	Y	N	Hives
Y	N	Artificial Bones/Joints/Valves	Y	N	Kidney Problems
Y	N	Asperger Syndrome	Y	N	Liver Problems
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Autism	Y	N	Lupus
Y	N	Cancer	Y	N	Measles
Y	N	Chicken Pox	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Mononucleosis
Y	N	Convulsions	Y	N	Prosthetics
Y	N	Diabetes	Y	N	Rheumatic Fever
Y	N	Epilepsy	Y	N	Scarlet Fever
Y	N	Exposed to HIV, but Neg.	Y	N	Skin Rash
Y	N	Handicaps/Disabilities	Y	N	Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences/ed:

_____

_____

Does/did the child experience any of the following?

Y	N	Breast Fed	Y	N	Nursing Bottle Habits
Y	N	Chewing on Objects	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Thumb/Finger Sucking
Y	N	Lip Sucking/Biting	Y	N	Tongue/Cheek Biting
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Used Pacifier

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.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. _____

Signature of Dentist Date

Dentist's Comments: _____

_____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. _____

_____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. _____

_____

_____

Parent/Guardian Signature Date

_____

Dentist Signature Date

_____

Parent/Guardian Signature Date

_____

Dentist Signature Date

COELLO DENTISTRY

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

COELLO DENTISTRY

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

COELLO DENTISTRY

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

COELLO DENTISTRY

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