Richard J. Garcia, D.M.D.

smilesofnaples.com
frontdesk@drgarcia.comcastbiz.net

7385 Radio Road | Suite 103 • Naples, FL 34104 (239)455-0898

PATIENT REGISTRATION FORM

We are pleased to welcome you to our practice. Please complete the following information thoroughly. We look forward to working with you in maintaining your dental health.

Today's Date: * _____

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____

SS#: ___-__-____

Prev. Visit: _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Are you a seasonal patient? ◯ Yes ◯ No

If seasonal please list which months in Naples.

_____

_____

How did you hear about our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact Name and number *

_____

_____

Relationship to Patient: _____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First M

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent for Services and Financial Policy

FINANCIAL POLICY

Our mission is to deliver the finest dental care available today. Fine dentistry is truly an investment; our goal is to help you make that investment possible. We are a fee per service practice; payment is due at the time dental services are rendered. Our practice is not an insurance provider. Patients with dental insurance will be provided with a completed claim form at checkout to submit to their insurance company for reimbursement based on their plan benefits. Please bring a copy of your dental insurance card, so that a claim form may be provided. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all services. Please remember insurance is a contract benefit between patient and the insurance company.

The following payment options are available for your convenience; check, cash, credit cards (Visa, MasterCard or Discover.) If you are paying by cash or check for treatments over $1,500 please ask about our pre-payment discount, when you pay in advance of your appointment.

Flexible monthy payment plans are available through Care Credit. Applications for Care Credit are available in our office or you may apply online at CareCredit.com

Treatment Plans presented for dental care can only be extended for a period of 3 months from the date of the patient examination and diagnosis. This is due to the fact that if left untreated, condition may worsen and may require more extensive treatment.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment.

APPOINTMENTS

We understand that an unforeseen emergency may arise at any time. Please be advised that in the event you have to re-schedule an appointment we ask for the courtesy of at least 24 to 48 hours advance notice, so that we may offer the time to another patient. We also reserve the right to charge a missed appointment charge of $50.00 if our office was not given advance notice or for 'no-shows.' We thank you in advance for your understanding in respecting the practice's time. As a courtesy we will text/email you appointment reminders in advance and we mail reminder post cards for all our hygiene appointments. We respectfully ask that you please confirm your appointments.

By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Registration Form.

Signature _____ **Date** _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient:

_____

_____

Name and Relationship to Patient:

_____

_____

By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Signature _____ **Date** _____

Response Date: _____

Richard J. Garcia, D.M.D.

smilesofnaples.com
frontdesk@drgarcia.comcastbiz.net

7385 Radio Road | Suite 103 • Naples, FL 34104 (239)455-0898

MEDICAL & DENTAL HISTORY FORM

Patient Name: _____ _____ ___ _____
Last First M Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?
☐ Are you currently under the care of a physician due to a specific condition?
☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
☐ Are you currently taking any prescription or non-prescription medications?
☐ Do you use tobacco (smoking or chewing)?
☐ Do you require the use of corrective lenses (contacts or glasses)?
☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

_____

_____

What is the reason for your dental visit today?

_____

_____

When was your last visit to the dentist (if to a different office)?

_____

_____

What was done on your last dental visit (if to a different office)?

_____

_____

Prior Dentist's name, address, & phone number:

_____

_____

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ Monthly ◯ Seldom ◯ Never

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

Please indicate if you have experienced any of the following:

☐ *NONE	☐ Allergies	☐ Allergy - Aspirin	☐ Allergy - Bactrim
☐ Allergy - Cat Dander	☐ Allergy - Codeine	☐ Allergy - Cycline's	☐ Allergy - Dyes
☐ Allergy - Erythro	☐ Allergy - Floxin	☐ Allergy - Furadantin	☐ Allergy - Gluten
☐ Allergy - Hay Fever	☐ Allergy - Iodine	☐ Allergy - Latex	☐ Allergy - Morphine
☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Allergy -Clindamycin
☐ Allergy-Amoxicillin	☐ Anemia	☐ Anesthesia Sensitivi	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Balck Plague Serum	☐ Blood Disease
☐ Blood Thinner	☐ Cancer	☐ COPD	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding	☐ Factor 5 Deficiency
☐ Fainting	☐ Fractured Ankle	☐ Glaucoma	☐ Head Injuries
☐ Headaches	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ Hip Revision	☐ HIV	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure	☐ Mental Disorders
☐ Nervous Disorders	☐ Other	☐ Pacemaker	☐ Pregnancy
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Stomach Problems	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

Do you have any other health issues or allergies? ◯ Yes ◯ No

If YES, please list below

_____

_____

Are you required to PRE-MEDICATE prior to dental procedures? * ◯ Yes ◯ No

Do you take BLOOD THINNER medication? * ◯ Yes ◯ No

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

_____

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

FOR OFFICE USE ONLY

DR SIGNATURE ONLY

Signature _____ **Date** _____

Response Date: _____