PATIENT INFORMATION

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

Name_____ SSN_____
Last First M

Address _____

City_____ State_____ Zip _____

Home Phone_____Mobile/Pager#_____Bus. Phone_____Ext._____Bus. Fax _____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Widowed ☐ Divorced ☐ Married

Patient Employed By_____ Occupation_____

Business Address _____ Supervisor_____

In case of Emergency, who should be notified?_____ Relationship_____ Daytime Phone _____

Spouse Name_____
Last First M

Employed By_____ Occupation _____

Business Address _____ Bus. Phone_____Ext. _____

Person Responsible for Account _____
Last First M

Primary Insurance

Name of
Insured _____
Last First M

Address (if different from patient's)

_____

City _____

State _____ Zip_____

Relation to Patient _____

Birthdate _____ SSN _____

Insurance Company _____

Employer _____

Group #_____ Subscriber # _____

Secondary Insurance

Name of
Insured _____
Last First M

Address (if different from patient's)

_____

City _____

State _____ Zip_____

Relation to Patient _____

Birthdate _____ SSN _____

Insurance Company _____

Employer _____

Group #_____ Subscriber # _____

Referred By_____Purpose of Call _____ _____

I hereby authorize payment directly to the Dental Office in the group insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I understand that I am financially responsible for all charges given if a 24 hour cancellation notice has not been given. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

_____ _____ _____
Patient or Responsible Party Signature **Date** **State Driver's License #**

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

DENTAL HISTORY

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last Visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional) _____ Yes No
Date of last full mouth x-rays (16 small films or panoramic): _____ Yes No

MEDICAL HISTORY

Are you under a physicians care now? Why? _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Yes No
_____
Natural Remedies? Vitamins? What? _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____
Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No
Do you now or have any of the following? Please check appropriate boxes.
*If yes to any of the **bold print** conditions, please call prior to your appointment... premedication may be required.

Yes	Yes	Yes	Yes	Yes
☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ **HEART MURMUR**	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ **ARTIFICIAL HEART VALVE**	☐ Drug Addiction	☐ **HEART PACE MAKER**	☐ **MITRAL VALVE PROLAPSE**	☐ Stroke
☐ **ARTIFICIAL JOINT**	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatment	☐ Tuberculosis
☐ Blood Transfusion	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ **RHEUMATIC FEVER**	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to your dentist privately about any problem? _____ Yes No

To the best of my knowledge all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

x _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)
Reviewed by Doctor _____ Date _____ BP _____
History Review and Significant Findings _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXPECTATIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____

Cubero Dental Associates, PA

5920 Cubero Dr. NE

Albuquerque, NM 87109

(505) 822-0663

FINANCIAL POLICY

Payment is expected at the time services are rendered. If you have dental insurance, we will collect your ***estimated*** portion at the time of treatment. As a courtesy, we will file your insurance claims to your insurance company. If there is any remaining balance after your insurance has paid their portion, the balance will be your responsibility.

If your insurance falls short and/or does not pay within 60 days, you will be responsible for the balance. A service charge of 1.50% will be added to all accounts over 60 days past due with a minimum finance charge of $1.00. Accounts over 90 days past due will be sent to a collection agency. All cost for overdue accounts, including legal fees, will be your responsibility.

Payment can be made in the following ways:

CASH CHECK VISA MC DISCOVER CARE-CREDIT CITI-BANK HEALTH CARD

Returned checks are subject to a return fee of $25.00.

Failure to keep an appointment without 24 hour notice will be subject to a reasonable fee of $50.00 per half hour for the amount of time for which you are appointed.

Please let us know if you have any questions. We will be happy to help you. We look forward to the opportunity to get to know you and your family and to be entrusted with your oral health.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE INFORMATION.

_____ _____

Patient/Guardian Signature Date

Cubero Dental Associates, PA

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Release of Information

I, _____, give my permission for Michael J. Farrell DDS, and/or James L. Zamora DDS to receive and/or give information pertaining to any x-rays and/or other pertinent medical/dental information that is part of my dental records/chart to authorized personnel (medical/dental referrals, or insurance).

_____ _____

Patient/Guardian Signature Date

(This document is HIPPA compliant)