SARMIENTO MICROENDODONTICS
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Patient Information

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we are happy to help you.

PERSONAL

Name _____
Last First MI (Preferred)
Birthdate _____ SS# _____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N
Address_____
City _____ State _____ Zip _____
Work Phone _____ Wireless Phone _____ Home Phone _____
Email _____
Preferred Contact Method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email
Student status if dependent over 19 (for ins) [ ] Non student [ ] Fulltime [ ] Part-time

General Dentist _____ Office Phone _____
How did you hear about us?_____
(If someone referred you here, please write down their name so we can thank them.)

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other _____
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____
Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other _____
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____

MEDICAL HISTORY

Name of Medical Doctor: _____ Office Phone: _____
Date of Last Physical Exam: _____ Height: _____ Weight: _____
Emergency Contact _____Phone _____ Relationship _____
List all medications that you are now taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you wish to speak to the doctor privately about anything? [ ] Y [ ] N
Have you had abnormal bleeding with previous extractions, surgery, or trauma? [ ] Y [ ] N
Have you ever required a blood transfusion? [ ] Y [ ] N
Have you ever had radiation for any condition? [ ] Y [ ] N
Have you ever tested positive for HIV infection or AIDS? [ ] Y [ ] N
If so, please state date diagnosed and treating doctor._____

Are you required to take antibiotics prior to dental treatment? [ ] Y [ ] N
(Usually required by medical physician after knee or heart surgery and other medical conditions)

Are you allergic to any of the following

[ ] Anesthetic	[ ] Ibuprofen	[ ] Penicillin
[ ] Aspirin	[ ] Iodine	[ ] Sulfa
[ ] Codeine	[ ] Latex	[ ] Other _____

Do you have or have you had any of the following medical conditions?

[ ] Asthma	[ ] Delay in healing	[ ] Hepatitis, jaundice	[ ] Psychiatric Treatment
[ ] Arthritis	[ ] Diabetes	[ ] High Blood Pressure	[ ] Rheumatic Fever
[ ] Bleeding problems	[ ] Emphysema	[ ] Infectious Mononucleosis	[ ] Sinus trouble
[ ] Blood disorder	[ ] Fainting spells or seizures	[ ] Joint prosthesis	[ ] Stroke
[ ] Bruise easily	[ ] Glaucoma or eye disease	[ ] Kidney disease	[ ] Tuberculosis
[ ] Cancer	[ ] Gallbladder trouble	[ ] Liver Disease	[ ] Ulcers, colitis
[ ] Cardiac Pacemaker	[ ] Heart disease	[ ] Low Blood Pressure	[ ] Venereal Disease
[ ] Chest pain, angina	[ ] heart Murmur	[ ]On a diet	[ ] Wear contact lenses

Do you have any disease, condition or problem not listed above? [ ] Y [ ] N
Specify. _____
Are you taking any herbal medicine (i.e., St. John's Wort)? [ ] Y [ ] N
Have you ever taken the "fen-phen" diet pill? [ ] Y [ ] N
Are you takin bisphosphonates now or have you taken them in the past (Fosamax)? [ ] Y [ ] N
Do you currently have or have you had a history of alcohol or drug abuse? [ ] Y [ ] N
Tobacco use? If so, what kind and how often? _____
Unusual reaction to dental injections? _____

WOMEN ONLY:
Possibility of pregnancy? [ ] Y [ ] N If yes, estimated delivery date. _____
Nursing? [ ] Y [ ] N
Taking birth control pills? [ ] Y [ ] N
Note: Anitibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of control.

Please note the reason for your visit: _____ Are you in pain? [ ] Y [ ] N

By signing below, you agree you have answered all questions honestly and to the best of your knowledge.

_____	_____	_____
Print Patient/Guardian Name	Signature Patient/ Guardian	Date

PHOTOGRAPH AUTHORIZATION

I hereby authorize **SARMIENTO MICROENDODONTICS** to take my or my child's photograph for inclusion in his/her medical chart retained by the clinic. I understand this photograph will be used for the purpose of identification and familiarization by the office staff, clinic physician(s), and consulting physicians. It may also be used on consult letters that we send to your or your child's other physicians.

_____
Initials

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of **SARMIENTO MICROENDODONTICS**.

_____
Initials

Financial Policy

I, the undersigned, authorize payment of dental benefits to **SARMIENTO MICROENDODONTICS** for any services furnished to me or my child by the doctor. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize **SARMIENTO MICROENDODONTICS** to release to my insurance, referring physician, or any other consultants on my case information concerning dental health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. For my convenience, this office may release my information to my insurance company, and receive payment directly from them. I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time. Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible. I will pay a fee for appointments broken without 24 hours notice. Treatment plans may change, and I will be responsible for the work actually done.

_____	_____	_____
Print Patient/ Guardian	Patient/Guardian Signature	Date

OFFICE POLICIES

In order to continue to serve our valued patients we have adopted the following policies:

1. **CANCELLATIONS:** We require at least a 48-hour notice for cancellation of appointments so that we may offer your appointment time to another patient. If you do not provide at least a 48-hour notice, you will be required to pay a $50 deposit in order to reschedule the appointment, this deposit will be used towards appointment cost. In the case that no treatment is recommended and there is no out of pocket cost to you, deposit will be reimbursed. Deposit is deemed non-refundable in the case that you no show to your appointment.
2. **TARDINESS:** Please notify us if you are expecting to be tardy as you may be offered an open time slot to better fit your schedule. If you are 15 minutes late or more, you may be rescheduled in order to accommodate our other patients' appointment slots.
3. **PRESCRIPTION REFILLS:** Patients must request refills by calling in to our office - 832-930-7870. In order to fulfill your request in a timely fashion, we request that you provide at least 3 days' notice if possible.
4. **After-Hours Calls**: After-hours calls will be directed to our automated answering service. For non-urgent matters, please leave a voicemail message which will be answered the following business day. You can also reach the on call doctor by following the prompts for any urgent concerns. For any emergency, please call 911.
5. **Dental Records**: You are entitled to your medical record. There is a $25.00 fee for release of medical records. This must be paid prior to the release of records and helps cover the cost of printing and shipping. Please allow one week to process your request. You can also view your medical record through our online patient portal.
6. **FAILURE TO PAY**: If you have dental insurance, please be aware that any quoted treatment plan IS AN ESTIMATE ONLY. Coverage may be different if your deductible has not been met, annual maximum has been met, if your coverage table is lower than average, your employment status has recently changed and/or many other variables. **You are responsible for any amount not covered by your insurance policy for any treatment rendered. FAILURE TO PAY YOUR ACCOUNT BALANCE WITHIN 90 DAYS OF THE FIRST COLLECTION LETTER SENT WILL RESULT IN YOUR ACCOUNT BEING FORWARDED TO A THIRD PARTY ADMINISTRATOR WITH A FEE OF 10% OF ACCOUNT BALANCE ADDED.**

*I have read and understand the policies set by **Sarmiento Microendodontics** and agree to the terms.*

_____	_____	_____
Print Patient/ Guardian	Patient/Guardian Signature	Date