Arthur J. Hernandez, D.D.S, P.A 1202 W. Bitters, Bldg. #5 San Antonio, Tx 78216 210-408-7182

PATIENT REGISTRATION

Patient's Name _____ Sex: ☐M ☐ F Birth Date ____/____/____ Age _____ Today's Date ____/____/____

Home Address _____ City _____ State_____ Zip _____

Please Check: ☐Single ☐Married ☐ Separated ☐Widow Hm Phone ( ) _____ Cell Phone ( ) _____

Occupation _____ Employed Work Phone ( ) _____

Your Employer _____ Your Soc. Sec. # _____-_____-_____

Are you a full time student? ☐Yes ☐ No If patient is a minor we need: Mother's Birth Date ____/____/____ Father's BirthDate ____/____/____

Person responsible for account _____ Driver's license # State _____

Name of spouse (Parent of minor) _____ Cell Phone ( ) _____

Spouse's (parent's) employer _____ Spouse's Soc. Sec.# _____-_____-_____ Work Phone ( ) _____

How did you hear about our office?_____ Reason for this visit _____

EMERGENCY INFORMATION: (Relative not living with you) Name _____ Phone ( ) _____

Address_____ City_____ State _____ Zip _____

DENTAL INSURANCE INFORMATION (Primary Carrier) Second Dental Insurance or Medical Insurance (if applicable)

Insured's Name _____ Insured's Name _____

DOB ____/____/____ SS# _____-_____-_____ DOB ____/____/____ SS # _____-_____-_____

Insured's Employer _____ Insured's Employer _____

Insurance Co. _____ Insurance Co. _____

_____ _____

Insurance Co. Address _____ Insurance Co. Address _____

_____ _____

Phone # ( ) _____ Phone # ( ) _____

Group # _____ ID#_____ Group # _____ ID# _____

RELEASE and ASSIGNMENT

I hereby authorize release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating billing and reimbursements, directly to the doctor, of benefits to which I am entitled.

Signature _____ **Date**_____ **Signature** _____ **Date**_____

FINANCIAL POLICY

Thank you for choosing **Arthur J. Hernandez, D.D.S, P.A.** as your oral surgery provider. We are committed to providing you with the highest quality of care. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and American Express.
PLEASE NOTE: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will of course, do all we can to make sure your estimate is as accurate as possible.

- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash check, MasterCard, Visa, Discover or American Express at the time we provide the service to you.

- Insurance payments are ordinarily received within 30-45 days from the time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.
I AUTHORIZE MY INSURANCE

Patient Signature: _____ Last 4 of social security #:_____

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HEALTH HISTORY FORM

Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Sex: M ☐ F ☐ Height: _____ Weight: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health? Yes ☐ No ☐
2. Has there been any change in your health in the past year? Yes ☐ No ☐
3. My last physical exam was on ____/____/____
4. Are you now under the care of a physician? Yes ☐ No ☐
   If so, for what condition?
5. The name and address of my physician is: _____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? Yes ☐ No ☐
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? Yes ☐ No ☐
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia) ? Yes ☐ No ☐
9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? Yes ☐ No ☐
   If so, please list: _____
   _____
10. Do you have or have you had any of the following diseases or problems? Yes ☐ No ☐
    a. Damaged heart valves, artificial valves or heart murmur Yes ☐ No ☐
    b. Rheumatic Heart Disease Yes ☐ No ☐
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition? Yes ☐ No ☐
       1. Chest pain upon exertion? Yes ☐ No ☐
       2. Shortness of breath after mild exercise? Yes ☐ No ☐
       3. Do your ankles swell? Yes ☐ No ☐
    d. Allergies Yes ☐ No ☐
    e. Sinus trouble Yes ☐ No ☐
    f. Asthma or hay fever Yes ☐ No ☐
    g. Fainting spells or seizures Yes ☐ No ☐
    h. Diabetes Yes ☐ No ☐
    i. Hepatitis, jaundice or liver disease Yes ☐ No ☐
    j. Frequent or recurring mouth sores Yes ☐ No ☐
    k. Thyroid problems Yes ☐ No ☐
    l. Respiratory problems, emphysema, bronchitis, etc. Yes ☐ No ☐
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) Yes ☐ No ☐
    n. Osteoporosis Yes ☐ No ☐
    o. Stomach ulcer or hyperacidity Yes ☐ No ☐
    p. Kidney trouble Yes ☐ No ☐
    q. Tuberculosis Yes ☐ No ☐
    r. Persistent cough or cough that produces blood Yes ☐ No ☐
    s. Persistent swollen neck glands Yes ☐ No ☐
    t. Low blood pressure Yes ☐ No ☐
    u. Epilepsy or neurological disorder Yes ☐ No ☐
    v. Cancer Yes ☐ No ☐
    w. Any disease, drug or transplant operation that has depressed your immune system Yes ☐ No ☐
11. Have you had abnormal bleeding? Yes ☐ No ☐
    a. Have you ever required a blood transfusion? Yes ☐ No ☐
12. Do you have any blood disorder such as anemia? Yes ☐ No ☐
13. Have you ever had treatment for a tumor or growth? Yes ☐ No ☐
14. Have you had radiation therapy to the head, neck or jaws? Yes ☐ No ☐
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics Yes ☐ No ☐
    b. Penicillin or antibiotics Yes ☐ No ☐
    c. Sulfa drugs Yes ☐ No ☐
    d. Barbiturates or sleeping pills Yes ☐ No ☐
    e. Aspirin Yes ☐ No ☐
    f. Iodine Yes ☐ No ☐
    g. Codeine or other narcotics Yes ☐ No ☐
    h. Latex or rubber products Yes ☐ No ☐
    i. Other (please list) _____

16. Have you had any serious trouble associated with previous dental treatment? . . . . . Yes ☐ No ☐
If so, explain: _____
17. Do you have any other condition or disease you think the doctor should know about? . . . . . Yes ☐ No ☐
If so, explain: _____
18. Do you smoke or chew Tobacco? . . . . . Yes ☐ No ☐
How much? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? . . . . . Yes ☐ No ☐
20. Are you wearing contact lenses? . . . . . Yes ☐ No ☐
21. Are you wearing removable dental appliances? . . . . . Yes ☐ No ☐
22. Do you wish to talk with the doctor privately about anything? . . . . . Yes ☐ No ☐

Women

20. Are you pregnant or trying to become pregnant? . . . . . Yes ☐ No ☐
21. Do you have problems associated with your menstrual period? . . . . . Yes ☐ No ☐
22. Are you nursing? . . . . . Yes ☐ No ☐
23. Are you taking birth control pills? . . . . . Yes ☐ No ☐

Chief Dental Complaint: _____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: _____/_____/_____ **Patient's Signature:** _____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____
_____
_____
_____

Significant findings from questionnaire or oral interview: _____
_____
_____
_____

Dental management considerations: _____
_____
_____
_____

Date: _____/_____/_____ Doctor's Signature: _____

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature: _____ **Date:**_____

Arthur J. Hernandez, D.D.S, P.A
ORAL AND MAXILLOFACIAL SURGERY

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Phone: _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to number indicated
- ☐ O.K. to text to cell phone

☐ Work Phone: _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other (Fax/Cell, etc.): _____

_____

I allow you to give my clinical information to or answer questions from (check all that apply):

- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Other (specify): _____
- ☐ None

_____ _____

Patient Signature Date

_____ _____

Print Name Birth Date