

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### PLEASE CIRCLE THE CORRECT ANSWER

- Yes No Are you good in health in general?  
Yes No Have you been hospitalized or had any serious disease in the past three years?  
If yes, why?  
Yes No Are you under any medical treatment? What for? \_\_\_\_\_  
Date of your last medical exam: \_\_\_\_\_ Date of your last dental appointment: \_\_\_\_\_  
Yes No Have you have any issues with any dental treatment in the past?  
Yes No Do you have any pain now? Explain: \_\_\_\_\_

### TAKING:

- Yes No Remedies, Medicine with or without prescription (including aspirin)

Please list all: \_\_\_\_\_

### DO YOU CONSUME

- Yes No Recreational drugs?  
Yes No Tobacco any type? How many a day? \_\_\_\_\_ Yes No Alcohol (Alcoholic drinks)?

### ONLY FOR WOMEN:

- Yes No Are you or could you be pregnant? How many weeks? \_\_\_\_\_ Yes No Are you breast feeding?  
Yes No Are you taking birth control pills?

### MARK ONLY IF YOU HAVE OR HAVE HAD IN THE PAST:

- |   |   |
|---|---|
| <input type="checkbox"/> Heart disease                    | <input type="checkbox"/> Covid-19                   |
| <input type="checkbox"/> Heart Attack                     | <input type="checkbox"/> AIDS o HIV positive        |
| <input type="checkbox"/> Heart Murmurs                    | <input type="checkbox"/> Tumors, Cancer             |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Alcohol abuse              |
| <input type="checkbox"/> Rheumatic fiber                  | <input type="checkbox"/> Arthritis, rheumatism      |
| <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Eye illness                |
| <input type="checkbox"/> Skin diseases                    | <input type="checkbox"/> Blood disease              |
| <input type="checkbox"/> Tuberculosis                     | <input type="checkbox"/> Anemia                     |
| <input type="checkbox"/> Emphysema                        | <input type="checkbox"/> Asthma                     |
| <input type="checkbox"/> Venereal disease                 | <input type="checkbox"/> Other pulmonary problems   |
| <input type="checkbox"/> Hepatitis or other liver disease | <input type="checkbox"/> Herpes                     |
| <input type="checkbox"/> Stomach problems, ulcers         | <input type="checkbox"/> Thyroid or glands problems |
| <input type="checkbox"/> Psychiatric treatment            | <input type="checkbox"/> Kidney problems            |
| <input type="checkbox"/> Radiation treatment              | <input type="checkbox"/> Hospitalizations           |
| <input type="checkbox"/> Chemotherapy                     | <input type="checkbox"/> Blood transfusions         |
| <input type="checkbox"/> Artificial Heart Valve           | <input type="checkbox"/> Surgeries                  |
| <input type="checkbox"/> Artificial Joint                 | <input type="checkbox"/> Pacemakers                 |
|   | <input type="checkbox"/> Seizures                   |

Specify \_\_\_\_\_

Yes No **ALLERGIES** (food, medicine, latex, others) Please specify

Yes No Do you have or had any other medical condition that we need to know about?

If yes, please explain: \_\_\_\_\_

*I acknowledge that I have answered completely and correctly to all the above questions. I will notify my dentist if there are any changes concerning my health or the medicine I take.*

Patient Signature or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

# Dentist Salud

Clara Lucia Nunez-Romero, DDS

## WELCOME

PLEASE ANSWER ALL THE FOLLOWING INFORMATION CLEARLY

Last Name \_\_\_\_\_ Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Nationality \_\_\_\_\_ Social Security \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

What is the best way to reach you? Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Emergency Contact

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone number (\_\_\_\_) \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Person responsible of payments if not the patient

Name: \_\_\_\_\_

Address : \_\_\_\_\_

City State Zip Code

Name of Employer: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

DOB: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Patient signature or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_



**APPOINTMENT CANCELLATION POLICY**

We understand that situations arise in which you must cancel your appointment. However, when you do not call to cancel your appointment, you may be preventing another patient from receiving treatment. It is therefore requested that you provide more than 24-hour notice when cancelling your appointment; allowing another patient the appointment time.

**Appointments which are cancelled with less than 24 hours notification, will be subject to a \$50.00 cancellation fee.**

**NO SHOW POLICY**

**Patients who do not show up for their appointments without calling to cancel, will be considered as NO SHOW and subject to a \$50.00 NO SHOW fee. Patients who NO SHOW two or more times in a 12 months period, may be dismissed from the practice and denied any future appointments.**

**The cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Insurance does not cover this charge.**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Legal Guardian's Name

\_\_\_\_\_  
Patient's Signature (or Legal Guardian)

\_\_\_\_\_  
Date

# HIPAA OMNIBUS RULE

## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

(You may refuse to sign this acknowledgement & authorization. If refusing, we may not be allowed to process your insurance claims)

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

\_\_\_\_\_  
Please print your name

\_\_\_\_\_  
Please sign your name

\_\_\_\_\_  
Legal Representative

\_\_\_\_\_  
Description of the Authority

Your comments regarding Acknowledgments or Consents: \_\_\_\_\_

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

First Name Only       Proper Sir Name       Other \_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:  
(This includes step parents, grandparents and any caretakers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENTS AND BILLING INFORMATION VIA:

- Cellphone Confirmation       Text Message to My Cell Phone  
 Home Phone Confirmation       Email Confirmation  
 Work Phone Confirmation       All of the above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- Cellphone Confirmation       Text Message to My Cell Phone  
 Home Phone Confirmation       Email Confirmation  
 Work Phone Confirmation       All of the above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFORMATION ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

- Phone Message  
 Text Message  
 Email  
 All of the above  
 None of the above (Opt out)

Signing this HIPPA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPPA Omnibus Rule, provide you this information with your knowledge and consent.

### Office use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- The patient was unable to sign because:
- Other (please describe)

\_\_\_\_\_  
Privacy Officer Signature