Welcome

We would like to welcome you and your child to our office. Our goal at Drs. Garcia and Sanchez-Garcia is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1. Tell us about your child

Today's Date: _____
Child's Name:_____
Birthdate:_____Age:_____
School:_____Grade:_____
Home #:_____SS#:_____
Child's Home Address:_____
_____

2. General Information

Mother's information (□Stepmother □Guardian)
Name:_____
Work #:_____Home#:_____
SS#:_____
Father's information (□Stepfather □Guardian)
Name:_____
Work:_____Home#_____
SS#:_____

3. Person Responsible for Account

Name:_____Relation_____
Billing Address:_____
_____
Work #_____Home#_____
Employer:_____
SS#:_____

4. Dental Insurance - Primary

Insurance Co. Name_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #_____
Group #:_____
Insured's Name:_____
Relationship to Patient:_____
Insured's Birthday:_____
SS#:_____
Insured's Employer:_____

Secondary Insurance information (if applicable)
Insurance Co. name:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #:_____
Group #:_____
Insured's Name:_____
Relationship to Patient:_____
Insured's Birthday:_____
SS#_____
Insured's Employer:_____

5. Has the child had any of the following medical problems?

Y N Heart Murmur Y N Heart Defect
Y N Cancer Y N Epilepsy
Y N Diabetes Y N Abnormal Bleeding
Y N Rheumatic Fever Y N Kidney Problems
Y N HIV+/AIDS Y N Liver Problems
Y N Hemophilia Y N Any stays in a
Y N Asthma hospital/Operations
Y N Hepatitis Y N Tuberculosis

Please discuss any serious medical problems that the child has had:_____
_____
Please list all drugs that the child is allergic to:
_____
Please list all drugs that the child is currently taking:_____
_____
Please describe the child's current health:
□ Good □ Fair □ Poor
Child's Physician:_____
Phone #:_____
Is the child currently under the care of a physician? □ Yes □ No

6. Why did you bring the child to the dentist today?_____

_____
Has the child ever had any problem associated with previous dental work? □ Yes □ No
Does the child have any of the following habits?
Thumb / Finger sucking □ Yes □ No
Nursing Bottle Habits □ Yes □ No

Does the child brush their teeth daily? □ Yes □ No
Floss their teeth daily? □ Yes □ No

7. I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status .

_____
Signature of parent or guardian Date

Medical History Update Date:_____
Comments:_____

Raul I. Garcia, D.M.D.
Concepcion M. Sanchez-Garcia, D.M.D.

Family, Cosmetic, and Implant Surgery

9301 Miller Road Suite A
Miami, FL 33165

Tel (305) 595-4616
Fax (305) 595-4927

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. If you have insurance you will pay your deductible, if applicable, and any portion we estimate your insurance will not pay. If you do not have insurance, then you will pay your balance unless our staff had previously approved payment arrangements. We accept cash, checks, Master Card, Visa, American Express, Discover, Dental Fee Plan and Care Credit. Care Credit is a dental credit card you can apply for. Dental Fee Plan is a payment plan. Please ask for more details if interested as this may offer you a payment plan with no interest for up to 12 months. We will be happy to help you process your insurance claim form and we generally accept assignment of insurance benefits for their portion of covered services.

We gladly accept your checks. When you provide a check as payment, you authorize us to use information from the check to make a one-time electronic fund transfer from your account, or to process the payment as a check transaction. You authorize us to collect a fee ($25 for checks $50 or less. $30 for checks greater than $50 and less than $300. $40 or 5% of face if amount greater than $300. Plus a bank fee if allowable by state law) through electronic fund transfer from your account if your payment is returned unpaid. Balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for broken appointments and appointments canceled without 24 hours notice.

We will gladly discuss your proposed treatment and answer any questions relating to your dental insurance.

You MUST realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above the information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.
Whom may we contact in the case of an emergency:

Name_____ Telephone_____

I understand and agree that in the event this office must go to an outside firm to collect the amount I owe, I will be expected to pay all costs for such actions, including reasonable attorney's fees.
I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered.
I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature_____ Date_____