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 hospital/Operations
Y N Asthma
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

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_____

Informed Consent for General Dental Treatment

Patient Name _____

Welcome to Miami Designer Smiles. Please know that we will do everything possible to help you achieve the results you have always wanted while making you feel comfortable and well cared for. Your dental treatment will be done while you are awake and with the help of local dental anesthesia. That means you will be breathing, swallowing and moving in response to the water and instruments used during dental procedures.

How does that affect you?

While we provide your dental work, we promise to be careful, gentle, and precise to get you the best outcome. Dental procedures are highly successful and although adverse outcomes are rare, they are possible and may look like but not limited to these mentioned below.
Please keep in mind that any adverse outcome is unintentional and inherent in treating human beings.

- Stretching and or chapping of the lips and mouth.
- Tenderness, redness, blanching and, or bruising of the face or in the site of injection or treatment.
- Discomfort to chew
- Tearing of the eye/eyes or eyelid weakness.
- Damage to adjacent structures.

Painful/sensitive teeth-- sometimes cavities are treated on teeth that had never caused you pain. After that the tooth may start to hurt as the cavity may have been deep and the tooth may need further treatment such as root canal or extraction. X-rays are excellent diagnostic tools and with their help, we do our best to predict when this may happen. Sometimes, there are circumstances that the tooth is in worse condition than anticipated and additional treatment may be needed to get the tooth healthy and get you out of pain. We will do our best to inform you of any change to the proposed plan as soon as we become aware of it. Altered nerve sensation or feeling. Temporary or prolonged.

Swallowing an instrument or piece of an instrument. Rest assured this is rare and dentistry has protocols all dentist should follow if this should happen. Luckily, most swallowed items in dentistry end up in the stomach and are naturally passed. There is, however, the need to take a patient to an imaging place for an x-ray to ensure it is on the way to the GI system

Cutting of lips or tongue. Sometimes during your swallowing and breathing or movements you cannot control, your soft tissue may run into a moving dental instrument and be hurt. Everything possible will be done to prevent this from happening and if it does, we may offer sutures or skin glue to repair the area and help you heal quickly.

Discomfort in jaw or muscles of face. These can last a few days and can last longer if the patient has a tendency towards these issues. These tendencies include any history ever of clicking and popping, headaches, neck aches, poor posture, ear aches, ear fullness, weird sensations upon swallowing, grinding or clenching of the teeth, mouth breathing, snoring, sleep apnea, wear facets on teeth, notches on neck of teeth, bone loss, recession of gums, marks on tongue, cheek biting, nail biting, tongue ties, vertigo, ringing of the ears, numbness or tingling into hands. Long list and not limited to these, but whether you are aware you have them or not any or all of these things place you at risk for developing sore jaws. Medicine and or supportive therapy may be recommended to help you feel better.

As mentioned, before we promised to do everything possible to give you the best result and to prevent any of the above from happening. You understand that dental work has risks you are willing to take as they rarely occur and are self-limiting as we will support your body's healing process.

Patient signature _____ **Date** _____