

WELCOME

The benefits of a happy and healthy smile are immeasurable!

Our goal at Dr. Garcia and Dr. Sanchez-Garcia's practice is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

PERSONAL

TITLE Mr. Mrs. Ms. ☐ Miss Dr. Rev. None
NAME _____
FIRST MI LAST

(H) ADDRESS _____
CITY STATE ZIP

(H) PHONE (____) _____

(W) PHONE (____) _____

Mobile (____) _____

EMAIL ADDRESS _____

SOCIAL SECURITY # _____

DRIVER LICENSE _____

BIRTHDATE _____

SEX Male ☐ Female

MARITAL STATUS Married Single Divorced Widowed

SPOUSE

TITLE Mr. Mrs. Ms. Miss Dr. Rev. None
NAME _____
FIRST MI LAST

EMPLOYER _____

(W) ADDRESS _____
CITY STATE ZIP

INSURANCE

NAME _____

ADDRESS _____
CITY STATE ZIP

PHONE (____) _____

GROUP # _____

DO YOU HAVE AN ADDITIONAL INSURANCE? YES NO

NAME _____

ADDRESS _____
CITY STATE ZIP

GROUP # _____

EMPLOYER _____

(W) ADDRESS _____
CITY STATE ZIP

OCCUPATION _____

HOW LONG HAVE YOU BEEN EMPLOYED THERE _____

Whom may we thank for referring you?

Previous Dentist _____

Last Dental Visit _____

(W) PHONE (____) _____

SOCIAL SECURITY # _____

BIRTHDAY _____

INSURED 'S NAME _____

SOCIAL SECURITY _____

BIRTHDAY _____

EMPLOYER _____

IF YES, PLEASE COMPLETE THE FOLLOWING:

INSURED 'S NAME _____

SOCIAL SECURITY _____

BIRTHDAY _____

EMPLOYER _____

I have reviewed the following treatment plan. I authorize release of any information this claim. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

I hereby authorize payment directly to the above named relating to dentist of the group insurance benefits otherwise payable to me.

X _____
SIGNED (PATIENT OR PARENT IF MINOR)

DATE

X _____
SIGNED (INSURED PERSON) DATE

HIPAA PRIVACY: _____
SIGNED

HEALTH HISTORY _____

Although Drs. Garcia and Sanchez–Garcia primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Today’s Date _____

Name _____ Birthday _____ Age _____

Why are you now seeking dental treatment? _____

1. Do you have or ever had any of the following?

	Yes	No		Yes	No
NERVOUS SYSTEM			CARDIOVASCULAR		
Stroke	-	_____	Rheumatic Fever.....	_____	_____
Epilepsy/Seizures.....	-	_____	Heart murmur.....	-	-
Psychiatric treatment.....	_____	_____	Chest Pain/Discomfort.....	-	-
Panic Attacks.....	_____	_____	Heart attack/trouble.....	-	-
Depression.....	_____	_____	Shortness of breath.....	-	-
ENDOCRINE			High blood Pressure.....	-	-
Diabetes.....	_____	_____	Congenital heart disease.....	-	-
Thyroid condition/ Goiter.....	_____	_____	Mitral valve prolapse.....	-	-
RESPIRATORY			Artificial heart valve.....	-	-
Tuberculosis.....	_____	-	Pacemaker.....	-	-
Emphysema.....	_____	-	Heart Surgery/surgical stent.....	-	-
Asthma/ hay fever.....	_____	_____	BONE/MUSCLE		
Sinus problems.....	_____	_____	Arthritis/rheumatism.....	-	-
DIGESTIVE SYSTEM			Artificial joints/limbs.....	-	-
Hepatitis.....	-	-	Osteoporosis.....	-	-
Ulcers.....	-	-	OTHER		
BLOOD			TMJ Pain.....	-	-
Bruise easily.....	_____	-	Radiation therapy.....	-	-
Anemia.....	_____	_____	Chemotherapy.....	-	-
Blood Transfusion.....	_____	_____	Cancer/Tumor.....	-	-
Hemophilia.....	_____	_____	HIV + or AIDS.....	-	-
			Venereal disease.....	-	-

2. List any allergic reactions to medicine, detergents, or herbal remedies.

3. Please give the name and the dosage of ANY MEDICINE with or without a prescription, or herbal remedies you are now taking.

4. Are you currently taking any medicine for osteoporosis such as: Fosamax, Boniva, Actonel, Zometa, or Aredia. If so, for how long _____.

5. (Women) Are you pregnant? If so, give the due date _____.

6. Do you use tobacco in any form? _____ If yes, how much per day and for how long? _____

7. Is there any disease, condition, or problem not listed above that you think we should know about?

8. Have you ever had? – Heavy bleeding following a tooth extraction _____.
– Any serious problems following a dental procedure. _____.

Please complete reverse side

If yes, please explain _____

9. Does dental treatment make you nervous? No Slightly Moderately Extremely _____

10. Check your level of dental anxiety: Mild Moderate Severe

11. Physician's name _____ Phone _____

12. Date of last dental visit _____

13. Please check any topic below you would like to know more about:

<input type="checkbox"/> Implants	<input type="checkbox"/> Facial Rejuvenation
<input type="checkbox"/> Periodontal therapy (Gum treatment)	<input type="checkbox"/> Botox
<input type="checkbox"/> Smile makeover	<input type="checkbox"/> Sedation dentistry
<input type="checkbox"/> Veneers	<input type="checkbox"/> Night guard for TMJ/Migraine therapy
<input type="checkbox"/> Crowns	<input type="checkbox"/> Restylane/ Perlane
<input type="checkbox"/> Wisdom teeth extractions	<input type="checkbox"/> Juvederm/ Juvederm Ultra
<input type="checkbox"/> Athletic mouth guards	<input type="checkbox"/> Smoking Cessation
<input type="checkbox"/> Tooth Whitening	<input type="checkbox"/> INVISALIGN orthodontic treatment

To the best of my knowledge, all of the preceding answers are true and correct. If ever I have any change in my health or medication, I will inform Dr. Garcia or Dr. Sanchez-Garcia at my next appointment.

Signature of Patient _____

Signature or Guardian _____ Date _____

I authorize Drs. Garcia and Sanchez-Garcia as he/she may select to photograph me. I understand the photograph will be used only for medical and educational purpose and will not be released for publication in any other context without my expressed written consent.

Signature _____

DENTAL PHOTO RELEASE

Your photos are part of your diagnostic and clinical record. We make use of radiographs, photographs, and digital images. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results, particularly remarkable smiles, or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, television, on digital media and on our webpage. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

Please Initial All Items Below That Apply:

_____	<div style="border: 1px solid black; padding: 2px;">I authorize the use of all images.</div>
_____	<div style="border: 1px solid black; padding: 2px;">I authorize the use of images where my face is not identifiable.</div>
_____	<div style="border: 1px solid black; padding: 2px;">Store images in my diagnostic record only.</div>

This authorization will remain in effect until cancelled. Any future cancellation will not affect the usability of images that have already been released. I have read and understand this form.

Signature _____ Date: _____

Print Name (Parent, if patient is a minor)

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

Family, Cosmetic, and Implant Surgery

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 _____

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 _____