Dr. Víctor Vergara DMD P.A. 239-263-0912
13180 Livingston Rd, Bldg # 100, Ste. #106, Naples, FL 34109
Fax 239-263-0925

PATIENT HEALTH RECORD

PATIENT INFORMATION

Date (Month/Day/Year)_____/_____/_____

DATE OF BIRTH _____/_____/_____

SOCIAL SECURITY NUMBER _____

LAST NAME_____NAME_____

MIDDLE INITIAL _____AGE_____ SEX F_____ M_____

EMAIL (for appointment reminder) _____

ADDRESS_____APT#_____

CITY_____STATE_____ZIP CODE_____

CELL #_____ HOME #_____ WORK #_____

PLACE OF EMPLOYMENT_____OCCUPATION_____

ADDRESS _____

MARITAL STATUS (X) SINGLE_____MARRIED_____WIDOWED_____DIVORCED_____SEPARATED_____

CREDIT CARD NUMBER _____ EXPIRES_____/_____/_____

RESPONSIBLE PARTY (For Patients Under 18) _____SOCIAL SECURITY_____

ADDRESS (If Different)_____TELEPHONE (If Different)_____

REFFERED BY: LAST NAME_____NAME_____

DO YOU HAVE DENTAL INSURANCE? YES_____ NO_____

NAME OF INSURANCE COMPANY _____

IN CASE OF EMERGENCY NOTIFY: LAST NAME_____ NAME_____

RELATIONSHIP WITH PATIENT _____TELEPHONE_____

MEDICAL HISTORY

HEALTH (X) EXCELLENT_____GOOD_____REGULAR_____BAD_____

HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST 2 YEARS? YES___ NO___

ILLNESS_____

NAME OF PHYSICIAN_____

LAST COMPLETE PHYSICAL DATE _____/_____/_____

ARE YOU TAKING ANY MEDICATION NOW? YES_____ NO_____ FOR WHAT PURPOSE_____

PLEASE LIST MEDICATIONS/DOSAGE: _____

PHARMACY NAME_____LOCATION_____PHONE #_____

MARK (X) ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

HEART CONDITION
BLOOD TRANSFUSION
BRUISE EASILY
RADIATION THERAPY (X RAY COBALT)
DIABETES
CHEST PAIN (ANGINA)
GLAUCOMA
ARTIFICIAL JOINT
GENITAL HERPES
HEPATITIS A
HEART PACEMAKER
FAINTING OR DIZZY SPELLS
TUBERCULOSIS T.B.
PSYCHIATRIC TREATMENT
YELLOW JAUNDICE
ACID REFLUX
ANEMIA OR HEMOPHILIA
CANCER OR TUMOR
KIDNEY TROUBLE
HEART MURMUR
CORTISONE MEDECINE
SWELLING OF ANKLES
VENEREAL DISEASE
LIVER DISEASE
ARTIFICIAL HEART VALVE
PAIN IN JAW AND JOINTS
EMPHYSEMA
EPILEPSY OR SEIZURES
HEPATITIS C
RHEUMATIC FEVER
DRUG ADDICTION
SKIN RASHES OR HIVES
HEART ATTACK OR STROKE
THYROID DISEASE
SHORTNESS OF BREATH
CHEMOTHERAPY (CANCER, LEUKEMIA)
SICKLE CEEL DISEASE
HEART SUGERY
ARTHRITIS OR RHEUMATISM
LUNG DISEASE
COLD SORES
HEPATITIS B
HIGH BLOOD PRESSURE
ALCOHOLISM
ASTHMA OR HAY FEVER
TESTED HIV POSITIVE

DO YOU NEED TO PREMEDICATE WITH ANTIBIOTICS PRIOR TO DENTAL PROCEDURES? NO_____YES_____

DO YOU HAVE ENDOCARDITIS? NO_____YES_____

DO YOU HAVE A CONGENITAL HEART CONDITION? NO_____YES_____

HAVE YOU EVER HAD A HEART TRANSPLANT? NO_____YES_____

DO YOU HAVE ANY ARTIFICIAL VALVES? NO_____YES_____

DO YOU HAVE ANY ARTIFICIAL JOINTS? NO_____YES_____

DO YOU HAVE ANY DISEASE CONDITION OR PROBLEMS NOT LISTED ABOVE? IF YES PLEASE EXPLAIN

ARE YOU ALLERGIC TO ANY MEDICINE, DRUG OR OTHER SUBSTANCE? NO YES

IF YES PLEASE EXPLAIN

DO YOU SMOKE? NO YES

ARE YOU SUBJECT TO PROLONGUED OR UNUSUAL BLEEDING? NO YES

HAVE YOU EVER BEEN HOSPITALIZED OR HAD ANY SURGERIES? NO YES

IF YES EXPLAIN

HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC? NO YES

HAVE YOU EVER HAD COMPLICATIONS FOLLOWING DENTAL TREATMENT? NO YES

HAVE YOU HAD AN INJURY OR TRAUMA TO YOUR FACE OR JAW? NO YES

ARE YOU SUBJECT TO FAINTING SPELLS? NO YES

ARE YOU NERVOUS OR CONCERNED ABOUT HAVING DENTAL WORK DONE? NO YES

WOMEN – ARE YOU PREGNANT? NO YES

IF YES IS THERE ANYTHING WE CAN DO TO MAKE YOU FEEL MORE COMFORTABLE?

DENTAL HISTORY

HOW LONG HAS IT BEEN SINCE YOU HAVE SEEN A DENTIST?_____

NAME OF PREVIOUS DENTIST _____

WHEN WAS THE LAST TIME YOU HAD YOUR TEETH PROFESSIONALLY CLEANED?_____

DO YOUR GUMS FEEL TENDER SWOLLEN OR BLEED?_____

HOW OFTEN DO YOU FLOSS?_____

DO YOU HAVE PAIN OR DISCOMFORT IN ANY PART OF YOUR MOUTH?_____

IF YES PLEASE EXPLAIN _____

DO YOUR JAWS EVER FEEL TIRED OR SORE?_____

DO YOU EXPERIENCE POPPING, CLICKING OR LOCKING? _____

IF YOU HAVE DENTURES PLEASE INDICATE

FULL UPPER _____FULL LOWER _____PARTIAL UPPER _____ PARTIAL LOWER _____

HOW OLD ARE YOUR DENTURES?_____

CONSENT

I acknowledge that I have read this document in its entirety, and any attachments, and that I fully understand it, and that all information I have presented is correct to the best of my knowledge.

I understand the above information is necessary to provide me or a dependent of mine with dental care in a safe and efficient manner. I hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. I further authorize doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in a connection with my treatment or that of my dependent, and also authorize and consent that doctor choose and employ such assistance as is deemed necessary.

Patient (or responsible party)_____ Date____/____/____

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges for dental services that either I have received or a dependent of mine has received through this office. I understand that payment is expected in full at the time services are rendered unless financial arrangements have been made prior to the initiation of treatment. If I fail to pay for these services, I agree to pay all costs of collection, attorney fees and court costs that are incurred in collecting for the services that were rendered. I further understand that a $10 (ten) late fee will be added to every 30 (thirty) days.

Patient_____Date___/____/____ Witness_____

Parent or Responsible Party_____

Relationship to Patient_____

PAYMENT OPTION AGREEMENT

As a courtesy to our patients with insurance, we are more than happy to file your insurance for you. However, we do require that you pay the estimated percentage your insurance does not cover plus your deductible at the time of your appointment**.**

I, _____, **understand that I am ultimately responsible for all costs of dental treatment:** unless other arrangements have been made, in writing, before treatment is rendered.

If you have insurance **please read** this important information.

On your first visit we will call your insurance company to verify your benefits and will review your treatment plan with you. Since insurance companies change their payment schedules, we cannot guarantee they will actually pay the estimated amount.

Please understand that an insurance company policy is not a "pay all", it is only assisting you in your dental care. **You are ultimately responsible for all cost of your dental treatment. Your insurance company has a responsibility to you, not us: therefore you must pursue the issue with them**. We have no control over how they make their decisions, and you, as the patient with benefits can make a difference. Please contact the insurance company immediately if there are any concerns. We will extend this credit for 60 days. After that our office policy requires you to pay the balance in full. **You must give us a credit/debit card number and expiration date to keep on file**. We will only charge the account if your balance is past due and we are unable to contact you. We will try to notify you, by phone calls and mail prior to any charges being made. It is your responsibility to please make sure your address and phone numbers are always updated. If your insurance company pays for the balance after the 60 days we will credit your account the full amount that was charged.

Most insurance companies pay a percentage of what they consider to be a customary fee for services. Therefore your portion may be more than the estimated amount on your dental treatment. Benefits may vary considerably from one plan to the next and are subject to eligibility: plan limitations, yearly maximums, and benefits used. The range of benefits depends entirely on what extend of coverage (extensive or minimal) the purchaser wishes to offer employees or members.

This practice has made the ethical decision to place composite (tooth colored) fillings instead of the mercury (silver) fillings**. Your policy may either not pay for the composite fillings or may offer an alternate benefit.** It is very important for you to know how your policy works and its benefits**.**

***Returned checks will have a minimum charge of $30.00**. Thereafter the balance is due in full either cash or credit card.
***Broken appointment fee of $50.00 per hour** will automatically be added by the computer system to patients who fail to keep or **reschedule appointments without a 48-hour notice.**
***In the event a delinquent account is placed for collection**, you will be responsible for all fees incurred in the collection of debt.

Signature_____ Date_____/_____/_____

Victor Vergara DMD, P.A._____ Witness_____

Credit Card # _____ EXP _____
VISA MASTERCARD DISCOVER AMERICAN EXPRESS

PATIENTS WITHOUT INSURANCE

Payment in full is required at the time services are rendered.
Note: If payment is made in full prior to completion of treatment by Visa, MasterCard, Discover, American Express, Care Credit, Capital one, or Chase a refund cannot be issued. You must follow through with the proposed treatment plan if it has been previously paid for.

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Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ DOB:_____

I have received this practice's Notice of Privacy Practices in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- ❑ **A statement that this practice is required by law to maintain the privacy of protected health information.**
- ❑ **A statement that this practice is required to abide by the terms of the notice currently in effect.**
- ❑ **Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.**
- ❑ **A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorizations.**
- ❑ **A description of uses and disclosures that are prohibited or materially limited by law.**
- ❑ **A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorizations.**
- ❑ **My individual rights with respect to protect health information and brief description of how I may exercise these rights in relation to:**
    1. **The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.**
    2. **The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a request restriction.**
    3. **The right to receive confidential communications of protected health information.**
    4. **The right to inspect and copy protected health information.**
    5. **The right to amend protected health information.**
    6. **The right to receive an accounting of disclosures of protected health information.**
    7. **The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.**

This practice reserves the right to change the terms of its Notice of Practices and to make new provision effective for all protected health information that information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____Date: _____

Relationship to patient (if signed by a personal representative of patient):_____