

Eaglesoft Medical History(Copy)(Copy)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs including blood thinners or aspirin?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?

Women: Are you...

- Pregnant/Trying to get pregnant?
Nursing?
Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin, Metal, Other, Penicillin, Latex, Codeine, Sulfa Drugs, Acrylic, Local Anesthetics

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

- AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problems/COPD, Bruise Easily, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pacemaker, Heart Trouble/Disease, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Yellow Jaundice

Have you ever had any serious illness not listed Yes No If yes

Comments:

Empty box for patient comments.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X \_\_\_\_\_

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

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder  Responsible Party Preferred Name: \_\_\_\_\_

**Responsible Party ( if someone other than the patient )**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

**Patient Information**

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

**Section 2**

**Section 3**

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg: \_\_\_\_\_

Referred By \_\_\_\_\_

Previous Dentist \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Emergency Contact # \_\_\_\_\_

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

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

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

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

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ Rem. Deduct: \_\_\_\_\_

# Miranda & Ortega D.M.D. P.A.

We would like to thank you and welcome you to our practice. We would also like to start by sharing with you what our guiding beliefs are for our patients. Our philosophy is to help each patient achieve the highest level of dental health that is appropriate for them recognizing that not all patients have the same needs or desires.

With that in mind we would ask you to identify how you would like to be seen in our office by checking which of the 3 levels seem appropriate for you at this time. Please understand that it is not uncommon for patients to choose a different path after they have experienced our office, but this helps as a starting point.

**Please circle which level of care best fits your dental needs and expectations**

## Level 1

Reactive Care:

- Only interested in urgent problems
- As inexpensive and efficient as possible

## Level 2

Proactive Care:

- Thorough examination
- Prevention of present and future diseases
- Typically choose repair solutions that are not long term

## Level 3

Regenerative Care:

- High Value for dental health
- Complete examination with a desire to be informed about longest lasting solutions

We hope these different levels make sense to you. As we stated to you before it is not uncommon for patients to change levels after beginning treatment with us. We look forward to seeing you and helping you achieve the level of dental care that is most appropriate for you.

Sincerely,



Dr Miranda and Dr. Ortega, D.M.D.

Effective date of notice: 1/1/2016  
**NOTICE OF PRIVACY PRACTICES**

Dr. Alex Miranda  
Dr. Jackie Ortega  
1298 N. Dixie Freeway, New Smyrna Beach, FL 32168  
386-428-2958 phone  
386-426-6590 fax  
mirandaandortega@yahoo.com

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

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We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

**TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

**USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to

- report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

### **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

### **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

### **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this

**Notice.**

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

**OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

**COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

**FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\* You May Refuse to Sign This Acknowledgement\*

I, \_\_\_\_\_, have received a copy of this  
office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but  
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Miranda and Ortega, DMD PA  
1298 N Dixie Freeway  
New Smyrna Beach FL 32168

**FINANCIAL POLICY**

Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

**FINANCIAL AGREEMENT:**

Patients are expected to pay for services at the time services are rendered. Patients with dental insurance are expected to pay the amount of their *estimated* copay and deductible at the time of service. We will do our best to give you an *estimate* of your investment in your dental health for each upcoming visit, based on your individual treatment plan. With a proper diagnosis and a timely treatment plan, most *estimates* we provide are accurate.

If your insurance policy restricts reimbursement to their fee schedule only, we will require payment in full at time of service. We will let you know if your policy falls into this category.

Please bring cash, check or credit card at the time of treatment. We also offer CARECREDIT or the CITI HEALTHCARD, financing options available only for healthcare expenses, with prior approval. Please ask a staff member for an application if you are interested in this payment option.

**APPOINTMENTS:**

Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member or within 30 days of treatment, whichever comes first. Amounts due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month.

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 24 hours notice for any cancelled appointment. Your account will be charged a broken appointment fee of \$75.00/hour for appointments missed without timely notification.

**INSURANCE INFORMATION:**

As a courtesy to our insured patients, we submit claims to your insurance company. We will help you receive your maximum allowable benefits. In order to do this please give us timely notification of any insurance changes.

*Our doctors will diagnose treatment based on your dental health not your insurance coverage.*

Dental insurance is actually a money benefit, typically provided by an employer, to help employees pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for a tooth that has extensive decay. However, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling.

If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and be reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided to you to assist with your inquiry to the insurance company.



Miranda and Ortega, DMD PA  
1298 N Dixie Freeway  
New Smyrna Beach FL 32168

**ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY**

I understand and accept the financial and dental insurance policies and have had any and all questions answered to my satisfaction. I agree to pay for all treatment in a timely fashion as described so as to avoid any additional fees. I understand that a refusal to sign the financial policy agreement may result in dismissal from this dental practice.

**For patients with dental insurance who prefer that their insurance company send payment to this office:** I hereby authorize my insurance benefits to be paid directly to Dr. Miranda and Dr. Ortega. I realize that I am responsible to pay for any deductible amount, my coinsurance portion and for any noncovered services. I understand that I am financially responsible for any and all charges for dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Dr. Jackie Ortega  
Dr. Alex Miranda

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Patient Name

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Patient Signature

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Date