CONFIDENTIAL INFORMATION QUESTIONNAIRE:

PATIENT'S NAME LAST FIRST MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PATIENT'S MAILING ADDRESS STREET APT # CITY STATE ZIP

PHONE # ( ) -	ALTERNATE# ( ) -	EMAIL ADDRESS

MARITAL STATUS ☐M ☐S ☐D ☐W ☐UNDER AGE 18	GUARDIAN'S NAME (IF MINOR)	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	WORK PHONE	OK TO CALL? ☐YES ☐NO

SPOUSE'S NAME LAST FIRST MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	WORK PHONE	OK TO CALL? ☐YES ☐NO

PERSONS WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)			
NAME	RELATIONSHIP	WORK #	HOME #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

In order to protect your personal information, we will NOT give information about your appointments or treatment to non-medical personnel without your permission. We will therefore be asking each patient or guardian to appoint people who may be an exception for us to share information with. This exception may include spouses or other family members or relations. If you agree that your spouse or family members may access such information, please list them below

1.____ Relationship to patient ______________________________

2.____ Relationship to patient ______________________________

3. ____ Relationship to patient ______________________________

CONSENT:

1. The undersigned hereby authorizes doctor to take X-rays, study models, photographs, or other diagnostic aids deemed appropriate by doctor to make a through diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that all +½% finance charge (18% APR) may be added to my account in addition to any collection charges.
4. I understand that, where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient/Parent Signature ____Date________________________

FOR OFFICE USE: ____________________________________DATE_______________

MEDICAL HISTORY

Patient Name____Nickname________________________________Age_____________
Name of Physician____
Most recent physical examination date_________________________________Purpose_______________________________________
What is your estimate of your general health? Poor________________ Fair________________ Good________________

HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO
Hospitalization for illness or injury………………...	☐	☐

Are you allergic to any of the following:

- ☐ Aspirin
- ☐ Penicillin
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Flouride
- ☐ Metals (gold, stainless steel)
- ☐ Latex
- ☐ Any other medication____________________

	YES	NO
Heart problems…………………………………………	☐	☐
Heart murmur………………………………………...	☐	☐
Rheumatic fever………………………………………	☐	☐
Scarlet fever…………………………………………..	☐	☐
High blood pressure…………………………………	☐	☐
Low blood pressure………………………………….	☐	☐
Stroke………………………………………………….	☐	☐
Taking Blood Thinners ……………………………..	☐	☐
Artificial prosthesis (i.e. heart valve or joints)……………	☐	☐
Anemia or other blood disorder…………………….	☐	☐
Prolonged bleeding due to a slight cut………..………	☐	☐
Emphysema………………………………………….	☐	☐
Tuberculosis………………………………………….	☐	☐
Asthma………………………………………………..	☐	☐
Sinus Problems……………………………….........	☐	☐
Kidney Problems………………………………….. …	☐	☐
Liver Disease…………………………………………	☐	☐
Jaundice………………………………………………	☐	☐
Thyroid or Parathyroid disease…………………….	☐	☐
High Cholesterol…………………………………….	☐	☐
Diabetes………………………………………………	☐	☐
Stomach or duodenal ulcers…………….	☐	☐
Arthritis…………………………………	☐	☐
Osteoporosis……………………………	☐	☐
Glaucoma………………………………	☐	☐
Head or Neck Injuries………………....	☐	☐
Epilepsy, Convulsions (seizures)……….	☐	☐
Viral infections and cold sores…………	☐	☐
Any lumps or swelling in the mouth……	☐	☐
Hives, skin rash, hay fever………………	☐	☐
Venereal diseases………………………..	☐	☐
Hepatitis (type____)…………………….	☐	☐
HIV / AIDS……………………………..	☐	☐
Tumor, abnormal growth………………	☐	☐
Cancer ……………..…………………...	☐	☐
Chemotherapy / Radiation ………………	☐	☐
Psychiatric treatment …. ………………	☐	☐
Antidepressant medication ……………	☐	☐
Alcohol / drug dependency ……………	☐	☐

ARE YOU:

	YES	NO
Presently being treated for any illness…...		
Aware of a change in your general health	☐	☐
A heavy smoker (1 pack or more a day)…	☐	☐
FEMALE – taking birth control pills……	☐	☐
FEMALE – pregnant……………………	☐	☐
FEMALE Hormone Deficiency…………	☐	☐
MALE – prostate disorders………………	☐	☐

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment
____

List any medications, herbal supplements, and/or vitamins you are currently taking ____
____

PLEASE ADVICE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient/Parent Signature____**Date**___________________

Doctor's signature____

DENTAL HISTORY

Referred by____

Previous Dentist____ How long______________________________________

Most recent dental exam___________________________________Most recent dental x-ray_________________________

Most recent dental treatment ______________________________

How often do you have your teeth cleaned? 3mo.______ 4 mo.______ 6 mo.______ 1 year or longer______

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
Unhappy with appearance of your teeth…………………………………………	☐	☐
Unfavorable dental experiences………………………………………………	☐	☐
Dental fears…………………………………………………………………	☐	☐
Problems with effectiveness or bad reactions to dental anesthetic……………	☐	☐
Orthodontic treatment (braces) when…………………………………………	☐	☐
Periodontal (gum) treatment when……………………………………………	☐	☐
Bleeding gums………………………………………………………………	☐	☐
Avoiding brushing any part of your mouth……………………………………	☐	☐
Part of your mouth is sensitive to temperature………………………………	☐	☐
Sore teeth……………………………………………………………………	☐	☐
A burning sensation in your mouth……………………………………………	☐	☐
Difficulty swallowing…………………………………………………………	☐	☐
An unpleasant taste or odor in your mouth……………………………………	☐	☐
Dry mouth, throat, and/or eyes………………………………………………	☐	☐
Jaw problems (temporomandibular joint)………………………………………	☐	☐
Difficulty opening your mouth widely………………………………………	☐	☐
Stiff neck muscles……………………………………………………………	☐	☐
Awaken with an awareness of your teeth or jaws……………………………	☐	☐
Tension headaches……………………………………………………………	☐	☐
Clench or grind your teeth……………………………………………………	☐	☐
Jaw clicking or popping………………………………………………………	☐	☐
Lost any teeth………………………………………………………………	☐	☐

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a partial or complete artificial denture, please complete the following:

YES	**NO**	(Please check Yes or No)
☐	☐	Has your present denture been relined? When___________________________________
☐	☐	Is your present denture a problem? Describe___________________________________
☐	☐	Satisfied with the appearance?____
☐	☐	Satisfied with the comfort?____
☐	☐	Satisfied with the chewing ability?____
		When did you receive your first partial or complete denture?_______________________
		How long have you worn your present denture?__________________________________

Patient/Parent Signature____Date_______________________

Doctor's Signature____

MISSED APPOINTMENT/LATE CANCEL POLICY

Thank you for choosing Flores Dental Care for your dental needs! We pride ourselves in our expert team and specialized care. We will tailor your treatment to your specific needs in each one-on-one appointment. Your appointment time is scheduled **exclusively** for you in an effort to best accommodate your schedule; we ask the same courtesy. Our staff will do our best to make sure that we run on time and make each appointment valuable to you and your needs. As a result of the time and energy placed into your treatment plan, we require a 24-hour cancelation notice. We understand that unforeseen circumstances occasionally occur, and you may be unable to keep your scheduled appointment. Please see our missed/canceled appointment guidelines below.

If you are unable to keep your scheduled appointment, we require a minimum of 24-hour notice (1-full business day) so that we may accommodate the dental needs of another patient. This guideline applies to both visits with our hygienists and our doctor.

Doctor/Hygiene Visits: All patients will receive the opportunity to miss one scheduled appointment. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In the event of a late cancel/failed appointment, the patient will be charged a $30.00 fee. This fee must be paid before your next scheduled visit.

Thank you for choosing Flores Dental Care as your dental health provider.

Dr. Sylvia R. Flores

Patient/Parent Signature: _________________________________ Date: ______________

1506 E. Griffin Parkway, Suite D
Mission, TX 78572
Phone (956) 583-0055
Fax (956) 583-0090
www.FloresDentalCare.com

Flores Dental Care

NOTICE OF PRIVACY PRATICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect December 18, 2012 and will remain in effect until we replace it.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations, for example:

Treatment: We may use of disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you. **Note: if you paid out-of-pocket** (or in other words, you have requested that we not bill your health plan) **in full** for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or healthcare operations and our practice will honor that request.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvements activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section if this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of health information, we will provide you with an opportunity to object to such uses or disclosures. In the event that your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may disclose your health information to provide you with an appointment reminder (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to looks at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you requested unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 for each page and postage if you want the copies mailed to you.

Disclosure Accounting: You have the right to receive a list of instances in which we or business associates disclose your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you requested this accounting more than once in a 12-month period, we may charge you reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to the additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must be explain why the information should be amended). We may deny your request under certain circumstances.

Notification of Breach: you have the right to receive a notification following a breach of unsecured Personal Health Information.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. You may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request.

We support you right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U. S. Department of Health and Human Services.

Contact Officer: Dr. Sylvia R. Flores
Telephone: (956) 583-0055
Fax: (956) 583-0090
E-mail: drflores@floresdentalcare.com
Address: 1506 E. Griffin Parkway, Suite D
Mission, TX 78572