

# Lockwood Commons Dental Care

Juan C. Mesia D.D.S. and Lia Patricia Gonzalez D.D.S.

4222 53<sup>rd</sup> Ave E • Bradenton • FL • 34203 • (941) 251-3995

Welcome, so we may provide you with the best possible care and get to know you better; please complete this Medical & Dental History Form. Please keep in mind that all information is kept Confidential.

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

Title: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr.

Preferred Name: \_\_\_\_\_

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

Address: \_\_\_\_\_  
City State Zip

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Sex: Male or Female D.O.B.: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Parent or Responsible Party: \_\_\_\_\_ DOB: \_\_\_\_\_

## Insurance Information

*Please fill this section out using the subscriber's information*

Insured Person's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

## Employment Information

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## How did you hear about us?

Yellow Pages ( ) Walk-In ( ) Mailer: Postcard ( ) / Coupon ( )

Internet Search ( ) Insurance ( ) \_\_\_\_\_ Other ( ) \_\_\_\_\_  
Company

Employee / Friend ( ) \_\_\_\_\_

*Name of Patient or Person that referred you*

Eaglesoft Medical History

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

Are you under a physician's care now?  Yes  No If yes \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Women: Are you...

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

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes \_\_\_\_\_

Do you use controlled substances?  Yes  No If yes \_\_\_\_\_

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

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

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: \_\_\_\_\_

# Dental History . . .

Are you currently having any Dental Problems at this time? \_\_\_\_\_

When was your last Dental Appointment? \_\_\_\_\_

Date of Last Cleaning: \_\_\_\_\_ Date of Last X-rays: \_\_\_\_\_

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

Name

Location

Phone #

What didn't you like about your previous office? \_\_\_\_\_

## *How often do you:*

Brush \_\_\_\_\_ Floss \_\_\_\_\_ Whiten \_\_\_\_\_

See your Hygienist for cleanings? \_\_\_\_\_

Have you ever been told/treated for Periodontal Disease? Yes No Date: \_\_\_\_\_

What dental products are you using at home? \_\_\_\_\_

## *Are your teeth Sensitive to:*

Heat: Yes No Cold: Yes No Sweets: Yes No Biting: Yes No

## *Do you notice?*

Bleeding upon brushing? Yes No Gum Recession? Yes No

Swelling of the Gum Tissue? Yes No Bad Breath/Taste? Yes No

Frequent Headaches Yes No Loose Teeth Yes No

Discomfort/Popping/Clicking of your Jaw? Yes No

Grinding or Clenching of your teeth? Yes No

Do you have a Night Guard? Yes No

## *On a Scale of 1-10 how would you rate your:*

Smile: \_\_\_\_\_ Dental Health: \_\_\_\_\_

Would you like your teeth: Whiter: Yes No Straighter: Yes No

If you could change one thing about your smile what would it be?

What can we do to make your visit more comfortable?



# Privacy Notice and Consent

Lockwood Commons Dental Care, Juan C Mesia, DDS and Associates; believes our patients have the right to Privacy and that their personal financial and health information should be kept confidential. Our belief in your right to privacy is nothing new. However, new laws now require that we notify you about our privacy in writing.

## How do we use your personal health information?

We will use your personal health information to provide, coordinate, or manage your dental treatment and any related services. This may include providing necessary information to pharmacy personal, laboratory technicians, or to third party health care providers. For example, we might need to disclose information, as necessary, to a home health agency that provides care to you, or to a physician or dental specialist to whom you have been referred to ensure that they have the necessary information to diagnose or treat you.

Personal information may be given to your insurance company if necessary to facilitate payment of your claims.

On occasion your personal information may be used for/in supporting the practices business operations. These activates include, but are not limited too, quality assessments activities, employee review activities, training of dental students, licensing, and conductions or arranging for other business activities. We may use a sign-in sheet at the receptionist desk where you will be asked to sign your name and indicate the practitioner you are to see. We may also call you by name in the reception area when ready to bring you back. We may use or disclose your protected health information, as necessary; to contact you to remind you of your appointment or discuss any questions we may have regarding your account.

We may also use or disclose your personal information in the following situations without your authorization as required by law: Public health issues/communicable diseases, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners request, research, criminal activity, national security, and workers compensation.

## What are your rights?

- You have the right to inspect and copy your personal information
- You have the right to request a restriction of your personal information.
  - This means you may ask us not to use or disclose any of your personal information for the purposes of treatment, payment, or operations.
  - You may also request that any part of your information not be disclosed to family members or friends who may be involved in your care or for that notification purposes as described in this Notice of Privacy Practices.
    - Your request must state the specific restriction requested, in writing, and to whom you want the restriction to apply.
- Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit the use and disclose of such information, it will not be restricted. You then have the right to use another Health Care Professional.
- You have the right to request/receive confidential communications from us by alternative means or at an alternative location.
- You may have the right to have your dentist amend your personal health information
- You have the right to receive an accounting of certain disclosures we have made, if any, of your personal health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object of withdraw as provided in this notice.

## Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You can be assured there will be no ill-will following a complaint by you.

This notice was published and becomes effective on/before December 10, 2010.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected personal/health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number (941)251-3995.

This is to certify that I have read and understand the above information. By signing this statement I am giving Lockwood Commons Dental Care, Juan C Mesia, DDS and its team member's permission to release my personal information as described above.

\_\_\_\_\_  
Signature of Patient / Legal Guardian

\_\_\_\_\_  
Date

# Office and Financial Policy

Welcome and thank you for choosing Lockwood Commons Dental Care for all your dental needs. We are committed to providing you with the highest quality of dental care, in an efficient, timely, and cost effective manner. We hope that by providing you with our policies in advance you will have a great experience with our office and gain a better understanding of the financial obligation related to your dental treatment.

## Treatment Plan

We have prepared for you an itemized Treatment Plan that outlines the sequence of dental services to be provided. The Treatment Plan reflects the clinical findings and standard of care procedures dentally necessary for you to attain the smile and overall dental health you are seeking. Due to the nature of dentistry, treatment and fees may change; if this occurs will inform you prior to rendering any services.

## Estimated Fees

The Treatment Plan has an estimation of what we *expect* your insurance carrier to pay. Each insurance benefit plan is slightly different in its covered services; it is the insurance carrier's discretion for final payment. If you have any questions on your insurance coverage, please feel free to contact your insurance company or your Employer's Human Resources Department.

We understand that your insurance carrier may deny, adjust, or pay an alternate benefit; so as a courtesy to you, we will send a bill for the amount due. Your insurance carrier will provide an explanation of benefits. There may be a balance due after your claim is processed by your insurance carrier. As the policy holder and account guarantor, you are responsible for all fees not paid by your insurance carrier.

## Insurance Benefits

As the insurance holder, you are responsible for knowing your insurance benefits and coverage. As a courtesy to you, we will accept the insurance assignment of benefit. We will gladly file your insurance claim on your behalf. We will allow 30 days from the date of service for the insurance company to pay. If the insurance carrier does not pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage/benefits (i.e. deductibles, non-covered services, co-insurance, pre-existing conditions, reasonable and customary charges, etc.) You are responsible for the timely payment of your account.

## Payment Types

Payment of fees is due at the time services are rendered. For your convenience, we accept Cash, Personal Checks (with Identification), Visa, MasterCard, Discover, Amex, and Debit along with Care Credit.

**There is a \$35 fee for all returned checks.**

## Payment Plan and Financing Options

As convenience for you, we have made arrangements with Third-Party Healthcare Lenders to provide a financing option that will allow you to pay for your dental care over an extended period of time. This option is based on Approval. Please ask our Financial Specialist how you can apply.

## No Shows and Cancellation Policy

48 hours notice is required for all cancellations. Each Patient is allowed **ONE** no show or cancellation without 48 hours notice without penalty. Any additional broken appointments will result in a \$40 charge to your account.

## Non-Payment Recourse and Disclosure

As a courtesy we do not charge interest on accounts until your account is outstanding past 90days. Any balances unresolved and outstanding past 90days without prior arrangements with our office will be sent to an Attorney or Collection Agency. A collection fee of 33% for balances less than 1 year; and 50% for balances over 1 year will be added to your account.

I have read, understand, and have agreed to the above office and financial policies. I hereby attest that I have given and agree to provide current personal, demographic, and insurance information and authorize release of information necessary to fill insurance and or collection of my account.

\_\_\_\_\_  
Signature of Patient / Legal Guardian

\_\_\_\_\_  
Date



# Lockwood Commons Dental Care

4222 53<sup>RD</sup> Ave E | BRADENTON FL, 34203 | (941) 251-3995

## Written Financial Policy

Thank you for choosing Lockwood Commons Dental Care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

### Payment Options:

You can choose from:

- Cash, Check, Debit, Visa, MasterCard, Discover Card or Amex

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of \$500 or more.

- Convenient Monthly Payment Options<sup>1</sup> from CareCredit Healthcare Credit Card

- o Allow you to pay over time
- o No annual fees or pre-payment penalties

### Please note:

Lockwood Commons Dental Care requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case and less any laboratory fees if they apply.

For plans requiring more than 3 appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of \$1000 or more, a 10% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.<sup>2</sup> Patient portion of the bill is due at time of service.

A fee of \$40 is charged for patients who miss or cancel an appointment without 48-hour notice.

Lockwood Commons Dental Care charges \$35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patient, Parent or Guardian Signature

Date

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Patient Name (Please Print)