R.M. Molina Dentistry
Dr. Rebecca Molina D.D.S.
Dr. Mirna Azer D.D.S.

GENERAL PATIENT INFORMATION

Patient's Last Name _____ Patient's First Name _____ Patient's Middle Initial _____

Date of Birth _____ Social Security # _____

Gender ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married ☐ Other

Has any member of your family been treated by our practice? ☐ Yes ☐ No

Whom may we thank for referring you? _____

CONTACT INFORMATION

Address _____

City, State, Zip _____

Email Address _____

Best Contact Number _____

EMERGENCY CONTACT

Emergency Contact Name _____ Phone Number _____ Relationship to Patient _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

Patient or Responsible Party Signature _____ Date _____

Patient Medical History

Patient Name _____

Are you under a physician's care now?	☐ Yes ☐ No	Physician_____Office Phone_____
Have you recently been hospitalized?	☐ Yes ☐ No	If yes, please explain:_____
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	Please list drugs:_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐No	
Are you on a special diet?	☐ Yes ☐No	
Do you use tobacco?	☐ Yes ☐No	
Do you use controlled substances?	☐ Yes ☐No	

Women: Are you:
Pregnant/Trying to get pregnant? ☐ Yes ☐ No **Taking oral contraceptives?** ☐ Yes ☐ No **Nursing?** ☐ Yes ☐ No

Are you allergic to any of the following?
☐**Aspirin** ☐**Penicillin** ☐**Codeine** ☐**Local Anesthetics** ☐**Acrylic** ☐**Metal** ☐**Latex** ☐**Sulfa drugs**
☐ **Other If yes, please explain:**_____

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

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

Patient Dental History

Name of Previous Dentist_____ **Date of Last Exam**_____
Previous Dentist's Location_____ **Date of Last Cleaning**_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	○	○
2. Are your teeth sensitive to hot or cold liquids/foods?	○	○
3. Have you had any orthodontic treatment?	○	○
4. Do you feel pain to any of your teeth?	○	○
5. Do you have any sores or lumps in or near your mouth?	○	○
6. History of any periodontal therapy?	○	○
7. Do you like your smile?	○	○
8. Have you had any head, neck or jaw injuries?	○	○
9. Do you bite your lips or cheeks frequently?	○	○
10. Have you ever had any prolonged bleeding following extractions?	○	○
11. Do you wear dentures or partials?	○	○
12. Do you have frequent headaches?	○	○
13. Do you clench or grind your teeth?	○	○
14. Have you ever experienced any of the following problems in your jaw?		
Clicking, popping	○	○
Pain (joint, ear, side of face)	○	○
Difficulty in opening or closing	○	○
Difficulty in chewing	○	○

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 _____ **DATE** _____

SIGNATURE OF DOCTOR _____ **DATE** _____

R. M. Molina Dentistry Inc.
7146 Hamilton Mason Rd.
West Chester, OH 45069
(513)759-5481

Office Financial Policy

I understand that the billing staff will file all claims for the services rendered, to my insurance company, if the dentist is a participating provider.

I, however, acknowledge that I am responsible for the balance that may be due at the time services are rendered to the dentist because of:

- Co-Insurance or co-pay amount
- Yearly deductible amounts
- Non-covered services
- Out-of-network charges
- Exhausted benefits
- Terminated coverage
- No insurance coverage
- Failure to respond to insurance carrier correspondence
- Failure to respond to coordination of benefits inquiry

I understand and am agreeable that the balance of my statement will be paid in full within 30 days. Accounts over 90 days are subject to 40% collection & attorney fee if turned over to our collection agency.

If I am unable to pay the entire amount (applies to the amount of $150.00 or more), I am responsible immediately upon receipt of the statement, to call the billing office at (513)759-5481. Under special circumstances, payment arrangements may be made with our billing office.

Credit balances under $40.00 will not be returned without a written request after 3 years.

We reserve the right to charge for appointments cancelled or broken without 24 hour advance notice. This charge will be $50.

Signature of responsible party Date

DRS. REBECCA MOLINA & MIRNA AZER

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional serves and care. Additional information is available for the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handles appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already of matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to normal procedures utilized within the office for the handling of charts, patient record, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenience for the practice and/or as requested by you. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access the PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, good or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.3

I _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature _____ Date _____