PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given tome under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- ➜ Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- ➜ Obtaining payment from third party payers (e.g., my insurance company);
- ➜ The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*; which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restrictions.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient's Name _____

Relationship to Patient _____

Signature _____

DR. RAMON BANA
Miami Sedation & Cosmetic Dentistry
2461 Coral Way
Miami, FL 33145

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Add us on www.FaceBook.com/DrRamonBana

WELCOME

PATIENT INFORMATION

Patient _____

Home Address_____

_____Zip Code_____

Sex _____ Age _____ Birth date _____

Patient's SS No. _____

Occupation _____

Employer _____

Address _____

_____Zip Code_____

Whom may we thank for referring you to our practice?

_____

DENTAL INSURANCE

Who is responsible for this account?

_____

Relationship to Patient _____

Birth date _____ SS# _____

Insurance Co. _____

Telephone No. _____

Group# _____ Group Name _____

Is patient covered by additional Insurance? _____

If yes, Insurance Co _____

Telephone No. _____

CONTACT INFORMATION:

Home telephone # _____

Work _____ ext _____

Cell # _____

Best time to reach you _____

E-mail _____

Would you like to be contacted by e-mail? _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone _____ Work _____ Cell _____

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT FIRST NAMED ABOVE, INCLUDING BUT NOT LIMITED TO WHATEVER DRUGS, MEDICINE, PERFORMANCE OF OPERATIONS, AND CONDUCT OF LABORATORY, X-RAY, OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING DOCTOR OR QUALIFIED DESIGNATE. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY THEM IN FULL AT THE TIME OF SERVICE. I ACKNOWLEDGE THAT IS MY RESPONSIBILITY AND NOT AN INSURANCE COMPANY TO PAY FOR ANY OR ALL SERVICES.

Signature _____ Date_____
Patient/Parent or Legal Guardian

HEALTH INFORMATION

Name _____ Date _____

Date of last health care exam_____ Reason for the exam?_____

Have you been hospitalized in the last 5 years? No Yes

If yes, reason for hospitalization: _____

Are you currently receiving medical care? No Yes If yes, nature of care: _____

Please list the names and phone numbers of the physicians who are currently providing your care:

1. _____
2. _____
3. _____
4. _____

For the following questions please circle yes or no based on your medical history. Your answers are for our records only and will be kept confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

Mitral Valve Prolapse	No	Yes	Previous Biopsies	No	Yes
Abnormal Heart Condition or Bacterial Endocarditis	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Abnormal Blood Pressure(High/Low)	No	Yes	Cancer or Tumors	No	Yes
Stroke	No	Yes	Osteoporosis or other Bone Illnesses	No	Yes
Epilepsy	No	Yes	Asthma	No	Yes
Kidney Disease	No	Yes	Joint Replacement	No	Yes
Anemia or Blood Disorders	No	Yes	Slow Healing of Wounds	No	Yes
HIV/AIDS or ARC	No	Yes	Abnormal bleeding from cuts	No	Yes
Diabetes	No	Yes	Rheumatic Fever	No	Yes
Hepatitis(Any Form)	No	Yes	Unintentional/drastic weight changes	No	Yes
Liver Disease(including Jaundice)	No	Yes	Latex Sensitivity	No	Yes
Glaucoma	No	Yes	Venereal Disease(STDs)	No	Yes
Arthritis, Rheumatism or other Inflammatory Disease	No	Yes	Fainting or Dizzy Spells	No	Yes
Emphysema or other Respiratory/Lung illnesses	No	Yes	Recurrent Illnesses	No	Yes
Chemotherapy or Radiation Treatment	No	Yes	Any other infections	No	Yes

Women:

Are you pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you under any form of birth control?	No	Yes

Have you been told that you need pre-medication prior to dental treatment? No Yes

Are you allergic or have you had a reaction to any of the following?

- Local anesthetic — No Yes
- Penicillin or any other antibiotic — No Yes
- Aspirin — No Yes
- Codeine — No Yes
- List any other allergies _____

Are you a smoker? No Yes
If so, how much do you smoke per day? _____

Do you consume grapefruit, grapefruit juice or extracts? No Yes

Are you taking any of the following medications:

- Tagamet(cimitidine) or Prilosec(omeprazole)? No Yes
- Dilantin or Tegretol No Yes
- Diflucan No Yes

Have you been treated with Bisphosphonate drugs? No Yes
(Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)
If so, when did the treatment begin?_____When did the treatment end?_____

Do you take Antacids? No Yes
If yes, how often? _____

Are you taking any herbal supplements? No Yes
If yes, which ones and how often:_____

Please list any medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health and medication.

_____ _____ _____
Patient(Print Name) Patient/Legal Guardian Signature Date

_____ _____
Dr. Ramon Bana Date

DOCTOR'S USE ONLY:

Comments on patients interview concerning medical history
_____
_____
_____ __

DR. RAMON BANA
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APPOINTMENT POLICY

We want our patients to know how much we value your business. In an effort to provide the highest quality dentistry at affordable fees, we request **72 hours** notice for any schedule changes that you may need in the future. It is also imperative to arrive on time to your scheduled appointment. Our office understands that sometimes emergency situations arise and we will handle each circumstance on an individual basis. We would like our patients to understand that tardiness and missed or broken appointments are hurtful in many ways. **First**, they may prevent another patient who needs treatment from getting the necessary care in a timely manner. **Second**, they delay your treatment and our ability to keep your oral health at optimum levels. Our practice does not have a tardiness or missed appointment problem and we do not anticipate this will change in the future. With this in mind we want you to be informed of our appointment policy so there are no misunderstandings in the future.

- There will be a charge of up to 25% of the appointment scheduled or based on an hourly rate for all missed appointments without 72 hour notice.
- Patients arriving more that 20 minutes late to their appointments may have to be rescheduled and a $25 charge may be applied.
- All appointments must be confirmed at least 24 hours prior. As a courtesy our office will call you to remind you of your appointment. If you do not become available or return our call we may have to forfeit your appointment. Charges will still apply.
- Each patient may miss one appointment due to emergency without 72 hour notice in a 12 month period.
- After a second broken appointment occurs we will not pre-appoint you for any future appointments without a credit card. Your name will be placed on a short call list and we will call you on days when there are openings in our schedule.
- A third missed appointment may result in your dismissal from our practice. We will be happy to forward your records to a dentist whose hours better fit your schedule.

We would like to thank you for your cooperation and understanding of our need to keep our commitment to all our patients.

I have read and understand this policy. I agree to adhere to it.

_____ _____

Patient Signature/Guardian Date

DR. RAMON BANA
Miami Sedation & Cosmetic Dentistry
2461 Coral Way
Miami, FL 33145

FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with updated information and educational tools so that you may fully participate in maintaining optimum oral health.

DENTAL INSURANCE

Our office personnel would be happy to assist you in determining your dental plan and benefits. However, you must realize that:

- Your dental benefits are under contract between You, your Employer, and the Insurance Company. We are not a party to that contract.
- We would request a predetermination of benefits based on the work you require. Partial payment is required prior to request.
- Because pre-determination of benefits is not a guarantee of payment. Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice.
- We perform routine insurance billing procedures upon verification of coverage and we will be more than happy to file insurance claims for you. However, full payment is required at the time that services are rendered.
- You are responsible for all fees incurred for services rendered to you.

PAYMENT OPTIONS

Our goal is to provide our patients with the best dental care possible. To help you receive this optimal care we offer a variety of payment options, including cash, check, and all major credit cards. We also offer financing through Care Credit, Citi Health one, Chase Health Advances and MedChoice.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS AGREEMENT.

_____
Print Name

_____ _____
Patient's Signature/Legal Guardian Date

Authorization for DR. BANA to Release Health Care Information

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

Doctor's Name: DR. RAMON BANA

Practice Name: Miami Sedation & Cosmetic Dentistry

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip code: _____

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

Or _____All health care information

Or _____Other:

_____

THIS AUTHORIZATION EXPIRES ON _____ or _____DAYS AFTER THE DATE IT IS SIGNED; or WHEN THE FOLLOWING EVENT OCCURS _____

_____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or

- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.

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Patient Smile Evaluation Form

Name:_____ Date:_____

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?	YES	NO
Do you have spaces between your teeth that bother you?	YES	NO
Do you have chips or uneven edges on your teeth?	YES	NO
Do you feel that your teeth are too long or too short?	YES	NO
Do you have dark fillings that show when you smile?	YES	NO
Are your teeth crowded or crooked?	YES	NO
Do you have existing crowns or dental work you consider ugly?	YES	NO
Are you self-concious of your teeth and/or smile?	YES	NO
Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile?	YES	NO
Do you avoid smiling when you have your picture taken?	YES	NO
Would you like to improve your existing smile?	YES	NO
Do you wish you had a new smile?	YES	NO

Place a checkmark next to which of the following concerns you have regarding dental treatment to improve your smile:

- ☐ Fear of Treatment
- ☐ Time of treatment concerns
- ☐ Distance to office
- ☐ Not understanding treatment
- ☐ Embarrassment
- ☐ Other