GALINDO PROSTHODONTICS

DANIEL F. GALINDO, D.D.S., P.C.

Board Certified by the American Board of Prosthodontics

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: M ☐ F ☐ Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Birth Date: _____ Age: _____ Drivers License: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Mobile Phone: _____

Address: _____
Street City State Zip Code

E-Mail: _____ ☐ I would like to receive correspondences via e-mail

NAME OF PARENT/PARTNER/SPOUSE/GUARDIAN

Name: _____
Last, First MI (Preferred Name)

Home Phone: _____ Work Phone: _____ Ext: _____ Mobile Phone: _____

Address: _____
Street City State Zip Code

☐ Responsible party for patient ☐ Primary insurance policy holder ☐ Secondary insurance policy holder

EMPLOYMENT STATUS

Employer Name: _____ Status: Full ☐ Part ☐ Retired ☐

Address: _____
Street City State Zip Code

EMERGENCY CONTACT

Contact Name: _____ Mobile Phone: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our office _____

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PATIENT NAME		DATE OF BIRTH
PHYSICIAN'S NAME	PHYSICIAN'S ADDRESS	PHYSICIAN'S PHONE
MOST RECENT VISIT	REASON	
YOUR GENERAL HEALTH IS?	☐GOOD ☐FAIR ☐POOR	

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	YES	NO
Are you currently seeing a physician for treatment of a recent or ongoing medial condition?	☐	☐
Have you been hospitalized within the last year? If yes, explain:	☐	☐
Have you had a serious illness or operation within the last year? If yes, explain:	☐	☐
Have you ever had any serious medical trouble associated with any dental experience? If yes, explain:	☐	☐
Have you ever been advised to take antibiotics (like penicillin, etc.) before dental treatment? Why?	☐	☐

Do you have or have you had any of the following cardiovascular diseases? Check all that apply:

- HEART DISEASE
- HEART ATTACK
- CORONARY BYPASS
- ANGINA
- MITRAL VALVE PROLAPSED
- HARDENING OF THE ARTERIES
- HIGH BLOOD PRESSURE STROKE
- HEART MURMUR
- CONGESTIVE HEART FAILURE
- RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER
- CONGENITAL HEART DEFECTS
- PROSTHETIC (ARTIFICIAL) HEART VALVES
- PACEMAKER
- SURGICAL IMPLANTED DEFIBRILLATOR
- HISTORY OF INFECTIVE ENDOCARTITIS
- SHORTNESS OF BREATH AFTER MILD EXCERSICE
- SHORTNESS OF BREATH WHEN YOU LIE DOWN
- SWELLING OF ANKLES
- CHEST PAIN UPON EXERTION
- ABNORMAL BLEEDING OR EXTENDED CLOTTING TIME

- **Diabetes ☐ yes ☐ no** If yes, do you require insulin? Type _____ Dose _____
- **Artificial Joints ☐ yes ☐ no** If yes, which joints? _____
- **Hepatitis ☐ yes ☐ no** If yes, circle type: (A) (B) (C) (OTHER) (NON-SPECIFIC) (DON'T KNOW)
- Have you ever required a **blood transfusion**? **☐ yes ☐ no** If yes, when? _____
- **HIV Positive? ☐ yes ☐ no**
- Do you have a reason to suspect you have been exposed to the HIV virus? **☐ yes ☐ no**

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- **Tuberculosis (TB) ☐ yes ☐ no** Have you had a TB test? **☐ yes ☐ no** Persistent cough? **☐ yes ☐ no**

Do you consider yourself currently under an abnormally high amount of stress?	☐ Yes	☐ No
When was your last complete physical exam with your physician including blood tests? Date: _____		
Do you now or have you ever smoked? If yes, how much?	☐ Yes	☐ No
Do you chew tobacco? If yes, how often?	☐ Yes	☐ No
Do you drink alcohol? If yes, how much?	☐ Yes	☐ No

Please check the box if you are taking any of these medications currently or if you have taken any of these medications within the last two (2) years.

☐ Antibiotics	☐ Antidepressants (Prozac)	☐ Antihistamines	☐ Blood Pressure Medication
☐ Blood Thinners	☐ Cortisone (Prednisone)	☐ Cholesterol Medication	☐ Decongestants
☐ Diuretics	☐ Hormones (BC or Estrogen)	☐ Inhalants	☐ Insulin
☐ Heart Medication (NG)	☐ Muscle Relaxants	☐ Pain Medication	☐ Sleeping Pills
☐ Thyroid Medication	☐ Tranquilizers	☐ Vitamins	☐ Others

Are you ALLERGIC (get hives, a rash, have trouble breathing) to any of the following?

☐ Penicillin	☐ Local Anesthetics	☐ Codeine	☐ Aspirin
☐ Barbiturates or Sedatives	☐ Tranquilizers	☐ Sulfa	☐ Tetracyline

Others: _____

Have you ever had an adverse reaction (nausea, dizziness) with any drug or medication? ☐ yes ☐ no
If yes, please indicate the medication and the reaction: _____
_____

Do you have any disease, condition or medical problem not listed you feel we should know about ? ☐ yes ☐ no
If yes, please indicate the condition: _____
_____

W O M E N O N L Y

Are you currently pregnant?	☐ Yes	☐ No
If yes, expected delivery date? _____		
Do you have regular gynecological checkups?	☐ Yes	☐ No
Have you reached menopause?	☐ Yes	☐ No
Are you on hormone replacement therapy?	☐ Yes	☐ No

Please list your current medications OR attach a list of your medications to this form:

_____
_____
_____

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Patient Signature	Date

DENTAL HISTORY

Date of Last Dental Visit: Last X-rays taken?:

Do you have your teeth cleaned regularly? ☐ Yes ☐ No If yes, where and how often?

What is the presenting problem?

What is the history of the problem?

What treatment outcome are you expecting?

Have you attempted to obtain the desire outcome?

What are your treatment priorities?

Additional comments:

BACKGROUND INFORMATION

Have you been evaluated for sleep apnea?	☐ Yes	☐ No	If yes, please explain:
Have you been evaluated for fibromyalgia?	☐ Yes	☐ No	If yes, please explain:
Have you been evaluated for MS?	☐ Yes	☐ No	If yes, please explain:
Have you been evaluated for gastric reflux?	☐ Yes	☐ No	If yes, please explain:
Do you have difficulty swallowing?	☐ Yes	☐ No	If yes, please explain:
Does your mouth frequently become dry?	☐ Yes	☐ No	If yes, please explain:

DENTAL HISTORY

Orthodontic treatment (braces or retainers)?	☐ Yes	☐ No	If yes, please explain:
Jaw surgery or teeth removed?	☐ Yes	☐ No	If yes, please explain:
Periodontal treatment (deep cleanings or surgery)?	☐ Yes	☐ No	If yes, please explain:
Do you clench or grind your teeth?	☐ Yes	☐ No	If yes, please explain:
Do you have a splint or nightguard?	☐ Yes	☐ No	If yes, please explain:
Do you have a history of facial muscle soreness?	☐ Yes	☐ No	If yes, please explain:
Have you experienced head or jaw injury?	☐ Yes	☐ No	If yes, please explain:
How often do you brush your teeth?			
How often do you floss your teeth?			

Are you now under the care of a general dentist? ☐ Yes ☐ No If yes, please explain:

Name of Dentist: Address: Telephone:

Have you ever had any complication following dental treatment? ☐ Yes ☐ No If yes, please explain:

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Are you happy with the appearance of your teeth? ☐ Yes ☐ No If no, please explain:

OFFICE POLICIES AND FINANCIAL ARRANGEMENTS

Welcome to Dr. Daniel F. Galindo's specialty practice in prosthodontics. We hope this information will answer some of your questions about our office's policies and financial arrangements. These are a very important part of your treatment. We require you to read and sign this document prior to any dental treatment is started.

Financial Arrangements

It is our policy to completely examine and discuss treatment plans with all patients or guardians before dental treatment is started. A complete estimate of fees and method of payment will be discussed after your initial clinical exam during the treatment plan conference. As a result of the amount of time that we invest in your treatment, along with material and overhead costs, full payment is expected at each appointment, in the form of cash, check, credit (MasterCard, Visa, American Express and Discover) or debit card. It is our policy to receive one half of the quoted fee in advance of treatment. The second and final payment is required prior to the placement of the final restorations. Interest charges (18% per annum) are placed on the account if payment is sixty days past due.

Dental Insurance

As a courtesy to our patients, we will be happy to complete and forward insurance forms relative to dental treatment, and we will do so without charge. However, in order to avoid misunderstandings, please read carefully and understand the following policies in regard to dental insurance benefits. Our professional treatment is rendered to you, not the insurance company; you are directly responsible to us for the obligation of payment of treatment. Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer. Our office is not responsible for the accuracy of co-payments, deductibles or other insurance benefits. We will do our best to see that you receive your full benefits within the structure of your particular dental plan. However, ultimate responsibility for payment is yours and your financial arrangements must be defined before dental treatment can begin.

Case Presentation and Treatment Planning Session

About 2 weeks after your New Patient Appointment, you will be scheduled for a Case Presentation and Treatment Planning Session. In the time between your initial and second appointments, Dr. Galindo will diagnose and treatment plan your case. Dr. Galindo's goal is to offer at least two treatment alternatives, whenever possible. At the CPTP Session, Dr. Galindo will present his clinical findings and treatment options, along with benefits and risks of each option. The fee for this session is $195 and payment is expected after this appointment. If you choose to proceed with treatment in our office, this amount will be credited back to your account.

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Appointment Policy

The complex nature of your dental treatment requires a series of appointments with explicit amounts of time periods between them to allow us to complete your treatment to the high standards that we constantly strive to achieve. Once your appointment schedule is determined, it is then coordinated with the dental laboratory in order to achieve a smooth progression of your treatment. If you constantly change the dates of your appointments, this affects the laboratory schedule of your treatment, and in this event we may not be able to complete your treatment on a specific date.

Should you need to change a scheduled appointment, we would appreciate the courtesy of being informed at least 48 hours in advance. If your appointment is for a half or full day, we request at least 3 working days notice. There will be a $125 charge per hour for failed appointments. All cancellation fees must be paid prior to scheduling another appointment.

Agreement

I accept full financial responsibility for the services rendered to me at Daniel F. Galindo, D.D.S., P.C. and understand that I am responsible for my dental cost, regardless of any insurance coverage. I have read, understood and agreed to the office policies and financial arrangements above.

Date	Print Name	Signature of Patient

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name: _____ SSN: _____
Address: _____ Telephone: _____

Section B: TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: Before signing this form, you will consent to our disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practice as described in our notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Ana M. Galindo **Telephone:** 602.441.5529 **Address:** 5533 E. Bell Road, Suite 120; Scottsdale AZ 85254

Right to Revoke: You will always have the right to revoke this consent at anytime by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand revocations of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: I, _____, have had full opportunity to read and consider the contents of this Consent form and your notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name: _____ Relationship to Patient: _____

Revocation of Consent
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment, activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* 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: _____

For Office Use Only

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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____
_____
_____
_____

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