fabulous
DENTISTRY
COSMETIC AND RECONSTRUCTIVE DENTISTRY

PATIENT INFORMATION

First Name: _____ Last Name: _____

Preferred Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female

Social Security: _____

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

Preferred Method of contact: _____ Best time to Contact: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Previous Dentist: _____ Dental Office: _____

Emergency Contact: _____ Cell Phone: _____

Relationship: _____

How did you hear about us?

◯ Sign outside
◯ Instagram
◯ Facebook
◯ Google
◯ I was referred by _____
◯ Other (please specify)_____

_____ _____

Patient Signature Date

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INSURANCE INFORMATION

*****Please provide your Dental Insurance information, NOT your medical insurance, as they are separate. We need this information at least 48 business hours before your appointment to assist in verifying your benefits and copay.*****

◯ No Dental Insurance

◯ Primary Insurance

Name of Insurance Company: _____ Phone Number: _____

Address: _____

City: _____ State: _____ ZIP _____

Policy Holder Name: _____ Birth Date: _____

Social Security: _____

Member ID: _____ Group #: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

Payment must be made in full at the time of receiving the treatment unless prior arrangements have been made and approved previously.

This office accepts insurance. Therefore I understand that I AM RESPONSIBLE FOR THE PAYMENT OF THE SERVICES RECEIVED, as well as for the payment of any co-payment or deductible that my insurance does not cover. I hereby authorize the direct payment to Fabulous Dental, PLLC of the dental insurance group benefits. I understand that I am responsible for the entire cost of the dental treatment. I authorize the release of any information, including the diagnosis and the treatment or examination records provided, and all the information necessary to obtain/secure payment from any/ all third-party payers.

_____ _____

Patient Signature Date

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FINANCIAL AND INSURANCE POLICY

Our goal is to provide the highest quality of dental care possible and to clearly communicate our financial policy.

I, _____agree to be responsible for payment of all services rendered to myself and my dependents. I understand payment is due at time of service. I understand any treatment feel will be honored up to 90 days from the date of examination. I understand, in order to collect any debt, my credit history may be checked through use of my social security number and any other information given.

I understand that there is a $30 monthly late fee if I do not pay my balance within 30 days of a statement due date. There is a $35 processing charge for insufficient funds or returned checks. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in order to collect payment due.

I grant my permission to this office to phone, text or email me to discuss my account, appointments, treatment, etc.

As a courtesy to me, I understand this office will file any dental insurance claims on my behalf. I hereby authorize release of all information needed in such claims and also authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 60 days, I agree to pay the full remaining balance.

I understand this office will always do the best to help me maximize my dental benefits; however, ultimately responsibility for payment is mine, and I am obligated and agree to pay this office in accordance with its credit terms and policy.

- ◯ I have read the above conditions of treatment and payment and agree to these terms.
- ◯ I do not agree to the terms above and/do not want to disclose my SSN. I realize this is my choice and I can still receive treatment here. I do understand this comes with the following changes: (1) All treatment will need to be paid in full at time of service, (2) Insurance will reimburse me whatever amount they allow (3) I must pay with credit, debit or cash, (4) No payment arrangements will be possible, and (5) My benefits cannot be verified and estimates will be less accurate.

_____ _____

Patient / Parent/ Guardian Signature (responsible party) Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and 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 healthcare 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 practices 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.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation 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.

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 and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____ _____

Patient / Parent/ Guardian Signature (responsible party) Date

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PHOTO/INTRAORAL IMAGE CONSENT FORM

This form is designed to obtain your consent for capturing and using the patient's photo or intraoral images for identification and other relevant purposes.

I hereby authorize Dr. Garcia and Fav-ulous Dental, PLLC to take and/or reproduce photographs or videos of my teeth or face for use in publications, presentations, patient testimonials, smile galleries, and marketing materials, including online platforms, social media, and/or the website.

In accordance with the law, we will not release any personally identifiable information without your prior written consent. As a parent or guardian, you have the right to revoke this consent at any time in writing.

○ I acknowledge that I have read and understand the above consent. I give my permission for clinical photographs and videos to be taken and used for scientific and marketing purposes, including in publications and presentations. By signing below, I understand and agree that these photos and videos may be used for educational and marketing purposes. I release Dr. Garcia and Fav-ulous Dental , PLLC from any liability related to this production. Additionally, I waive any right to royalties, fees, or the ability to review the finished production or any advertising materials associated with these images.

○ I Grant permission for photos /intraoral images of the patient to be taken and/or submitted, with or without any other personal identifiers, to insurance companies as required for dental prior authorizations, claims for services rendered, and/or approval of dental benefits.

Refusal only:

○ I DO NOT GRANT permission for any photo/intraoral image to be taken of the patient under any circumstance.

_____ _____

Patient / Parent/ Guardian Name (print) (responsible party)

Date

_____

Patient / Parent/ Guardian Signature (responsible party)

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APPOINTMENT CONFIRMATION, CANCELLATION AND NO SHOW PROTOCOL

Due to high demand for service, when you book an appointment for your regular cleaning with Dr. Garcia or Dr. La and all other doctors and hygienists, a non refundable deposit of $100.00 will be collected.

All cancellations must be done 48 hours prior to the appointment time in order to not be charged. If you cancel less than 48 hours prior to your appointment or no show your deposit will be lost.

When booking an appointment for treatment, we offer a 5% discount with full pre-payment in cash at the time of scheduling. We will collect a non-refundable deposit of $100.00 per hour that is booked to reserve your spot on the doctor's schedule. We advise you to keep your appointments to prevent further damage to the treatment in question.

All appointments must be confirmed at least 48 hours in writing via text message, write "confirmed" "I will be there" or "yes". Or you can also confirm by calling the office to let us know if you will be keeping your appointment.

If you do not confirm your appointment, we reserve the right to offer the appointment to the next patient.

All cancellations must be made in advance at least 48 business hours.

Monday appointments need to be canceled/rescheduled by Thursday the week before your Monday appointment.

Thank you for your understanding and cooperation.

Sincerely,

Fabiola Garcia, DDS

Andrew La, DSS

All other associates/doctors/hygienists

_____ _____

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CUSTOMIZING YOUR PATIENT EXPERIENCE

Welcome to Fabulous Dentistry! We're excited to make your experience with us outstanding.
Please fill out this form and select just one response to help us serve you better.

1. What do we have to do to create the best patient experience for you?
   - ◯ Provide direct answers to my questions. I already know what I want to have done and my budget.
   - ◯ Give me the solution that will help me to look and feel my best.
   - ◯ Support me throughout the process to provide a comfortable experience.
   - ◯ Show me exactly what to expect from every step of the process.
2. How would you describe your feelings about coming in today to meet the Doctor and our team?
   - ◯ Indifferent, I have no strong feelings either way.
   - ◯ I am excited to learn more about my treatment options. It's time to do something.
   - ◯ I want to be reassured this is the right place for me. I have not had the best experiences in the past.
   - ◯ I need more information to make an informed decision.
3. Which reason would most relate to why you are thinking of having a consultation/appointment today?
   - ◯ It's time to have some work done and it's time to take care of ME for a change.
   - ◯ The most important thing to me is to look and feel my best.
   - ◯ I have a special event coming up.
   - ◯ I need to have all of my questions answered.
4. If you were to have any treatment done right away, what would be the reason?
   - ◯ I have the answers I need in order to complete my research to know this is the right decision for me
   - ◯ I could not make a decision without the support of _____
   - ◯ I realize Fabulous Dentistry is the right place to help me look and feel my best.
   - ◯ I have the confidence this is the right procedure in order to improve my dental situation.
   - ◯ The treatment option(s) presented fit into my budget.
5. How would you best handle people around you not understanding your decision to improve your quality of life?
   - ◯ I'll make the right decision for me based on the information I gather.
   - ◯ It would be a tough decision if those important to me didn't support this decision.
   - ◯ I will still have to make the decision knowing that I'll look and feel better.
   - ◯ It won't change my decision.
6. What do you need to know about the Doctor to feel certain about improving the quality of your life?
   - ◯ I need to understand the Doctor's expertise and skill level and to know that he is capable with my unique situation.
   - ◯ I need to feel completely comfortable with the environment and also like the Doctor.
   - ◯ I need to know that the Doctor will help me to look and feel my best.
   - ◯ Fabulous Dentistry is the best option to treat my dental situation.
   - ◯ I need to know that your team cares enough to listen to what matters most to me

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MEDICAL HISTORY

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
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	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ 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
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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 my medical status

_____ _____

Patient / Parent/ Guardian Signature (responsible party) Date