



Buena Vida Dental Studio is committed to providing you with the best dental care available. We have found that a clear understanding of our office financial guidelines relieve some of the anxiety associated with going to the dentist. We want to be certain that our guidelines are clear and that all of your questions are answered to your satisfaction. For your convenience we honor several different payment plans.

Payment Options:

We ask that you pay for your dental services in full at the end of each appointment. We gladly accept Cash, Check, MasterCard, Visa, Discover and American Express. We also offer our Buena Vida Dental Membership Plan for those without insurance as an added value to you.

Dental Insurance:

As a courtesy we will file your insurance claim for you. We will make a good faith estimate for planned treatment, there may be a difference between the estimated reimbursement and actual payment. As a service to you, we will complete and file the appropriate claim forms with your insurance carrier(s). We are happy to provide any x-rays and additional information they might require. If your insurer denies coverage or delays payment beyond 60 days from the claim filing date, the entire amount will become due and payable by you. Although we make every effort to help you obtain your full benefit, there are many variables we cannot anticipate nor control. Please be aware that your insurance benefits are a contract between you, your employer (if applicable) and insurance company.

Financial Services:

We offer Care Credit and Proceed Finance services that allow you to pay over time with convenient monthly payments. For more information please inquire with the business team.

We Would Also Like You to Know:

- Our office requires a minimum of 2 business days notice (longer if possible) if you are unable to keep your reserved appointment time.
- YOUR APPOINTMENT IS SPECIFICALLY RESERVED FOR YOU. A fee of \$50 per hour of missed appointment time will be charged to the patient for any appointment that is canceled without at least two business days' notice.
- There will be a \$25.00 charge for unpaid returned checks.

I authorize payment to be made directly to Buena Vida Dental Studio by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical information requested by my insurance carrier. I agree to pay interest of 1.5% (18% annually) on any balance over 30 days. I hereby agree that in the event of default of any amount due, and if this account is placed with a collection agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including any attorney fees and court costs incurred and permitted by laws governing these transactions up to 50% of the family's total balance.

SIGNATURE OF PATIENT / GUARDIAN

Patient/Parent or Guardian	Signature Printed	Name Date
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BUENA VIDA
DENTAL STUDIO

Patient Information

Patient Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

CellPhone: _____ HomePhone: _____

Email: _____ Married _____ Single _____ Child _____

Gender: _____ Age: _____ Date of Birth _____ Social Security #: _____

ReferredBy: _____ Employer: _____

Occupation: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Parent/Guardian Information (If under the age of 18)

Parent/Guardian Name: _____ Relationship to child: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Gender: _____ Age: _____ Date of Birth: _____ Social Security #: _____

Employer: _____ Occupation: _____

Work Address: _____ WorkPhone _____

Insurance Information

Primary Insured (Subscriber): _____ Relationship to Patient: _____

Date of Birth: _____ Subscriber ID#: _____

Insurance Company: _____ Group # _____

Subscriber Employer or Plan Sponsor: _____

Additional Insurance

Primary Insured (Subscriber): _____ Relationship to Patient: _____

Date of Birth: _____ SubscriberID#: _____

Subscriber Employer or Plan Sponsor _____

Insurance Company: _____

Authorization and Release

I authorize my insurance company to pay Buena Vida Dental Studio all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance. Buena Vida Dental Studio** may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services, as pertaining to HIPAA .

Patient/Parent or Guardian Signature

Printed Name

Date

Dental History

Reason for today's visit: _____

How often do you brush? _____ How often do you floss? _____

Approx date of last dental visit: _____

Please mark all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> TOOTHACHE | <input type="checkbox"/> SENSITIVITY | <input type="checkbox"/> GUMS |
| <input type="checkbox"/> LOOSE, CHIPPED, CRACKED OR BROKEN FILLINGS | <input type="checkbox"/> COLD | <input type="checkbox"/> BLEEDING |
| <input type="checkbox"/> LOOSE, CHIPPED, CRACKED OR BROKEN TEEETH | <input type="checkbox"/> HOT | <input type="checkbox"/> TENDER OR SORE |
| <input type="checkbox"/> FOOD CATCHES | <input type="checkbox"/> SWEET | <input type="checkbox"/> LOOSE TEETH |
| <input type="checkbox"/> FLOSSING BREAKS OR HURTS | <input type="checkbox"/> CHEWING | <input type="checkbox"/> TEETH HAVE SHIFTED |
| <input type="checkbox"/> PAIN, CLICKING OR POPPING OF -A- | <input type="checkbox"/> TOUCH | <input type="checkbox"/> BAD BREATH |
| <input type="checkbox"/> GRINDING OF TEETH | <input type="checkbox"/> SINUS PROBLEM | <input type="checkbox"/> BAD TASTE IN MOUTH |
| <input type="checkbox"/> CLENCHING OF JAW | <input type="checkbox"/> GAGGING | <input type="checkbox"/> SORES OR GROWTHS IN MOUTH |
| <input type="checkbox"/> HEAD ACHEs | <input type="checkbox"/> DRY MOUTH | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> SNORING / SLEEP APNEA | <input type="checkbox"/> DARK OR WHITE SPOTS ON TEETH | |

Medical History

Please mark all that apply:

Have you been: Hospitalized? Are You Taking Medication? Do You Have Allergies?

Please describe: _____

YES NO

- *PRE-MED - AMOX
- *PRE-MED-CLIND
- *PRE-MED-OTHER _____
- ALLERGY - ASPIRIN
- ALLERGY - CODEINE
- ALLERGY - ERYTHRO
- ALLERGY - HAY FEVER
- ALLERGY - LATEX
- ALLERGY - PENICILLIN
- ALLERGY - SULFA
- ALLERGY - OTHER _____
- ANEMIA
- ARTHRITIS
- ARTIFICIAL HEART VALVE
- ARTIFICIAL JOINTS
- ASTHMA
- BACK PROBLEMS
- BIPHOSPHATE MEDS
(FosaMax, Aceto , Ate v z, D drone , Bon va)
- BLEEDING DISORDERS
- BLOOD THINNERS
- BLOOD DISEASE
- BLOOD TRANSFUSION

YES NO

- CANCER _____
- CHEMICAL / DRUG DEPENDENCIES
- CHEMO THERAPY
- CIRCULATORY PROBLEMS
- CORTISONE TREATMENT
- DIABETES
- DIZZINESS
- EPILEPSY
- FAINTING
- GLAUCOMA
- HEAD INJURIES
- HEART DISEASE
- HEART MURMUR
- HEART PROBLEMS
- HEMOPHILIA
- HEPATITIS
- HIGH BLOOD PRESSURE
- HIV
- JAUNDICE
- KIDNEY DISEASE
- LIVER DISEASE
- MARIJUANA USAGE
- MENTAL DISORDERS

YES NO

- MITRAL VALVE PROLAP
- NERVOUS DISORDERS
- NURSING
- PACEMAKER
- PERSISTENT COUGH
- PREGNANT
- RADIATION TREATMENT
- RESPIRATORY PROBLEMS
- RHEUMATIC FEVER
- SCARLET FEVER
- SHORTNESS OF BREATH
- STROKE
- SWELLING FEET / ANKLE
- TAKING BIRTH CONTROL
- THYROID CONDITION
- TOBACCO USAGE
- TONSILLITIS
- TUBERCULOSIS
- ULCERS
- VENEREAL DISEASE
- OTHER _____

Physicians Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

To the best of my knowledge the above information is accurate and complete. I will not hold the doctor or any members of their staff responsible for any errors or omissions I may have made in the completion of this form.

PATIENT / GUARDIAN SIGNATURE

PRINTED NAME

DATE

DR.'S SIGNATURE

DATE