FAIRFIELD SMILES BY DESIGN
COSMETIC AND IMPLANT DENTISTRY

New Patient Registration Form

Date: _____

Mr. Mrs. Ms. Miss Dr. First Name _____MI____ Last Name_____

Preferred Name: _____Spouses Name: _____Birth Date: _____/_____/_____

Social Security #: _____-_____-_____ Driver's License # _____ State _____

Address_____City_____State_____Zip Code_____

Cell Phone #: _____Home: _____ Work: _____

E-Mail: _____Best time to call: _____

What is the best way to contact you and hear back from you quickly: _____

As a courtesy to our patients we use a texting and email messaging system to confirm appointments.

Would you like to be reminded of your appointments in this manner: _____Yes _____No

Which would you prefer: _____Text only _____Email only _____Both email and text _____Telephone call only _____None

How did you hear about our practice? _____

Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for the person responsible for payment: _____self _____ spouse _____ parent or guardian

Name: _____

Birth Date: _____/_____/_____Social Security #: _____-_____-_____ Driver's License # _____ State ____

Address_____City_____State_____Zip Code_____

Phone (Cell): _____ (Home): _____ Work: _____Ext. _____

E-Mail:_____ Fax: _____Best time to call: _____

Employment Information:

The following is for the patient:

Employer Name: _____ Occupation: _____

Address: _____City_____State_____Zip Code_____

The following is for the person responsible for payment:

Employer Name: _____ Occupation: _____

Address:_____City_____State_____Zip Code_____

Telephone #_____

Health Information

Although dental visits 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 medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions honestly.

Patient Name: _____ Today's Date _____

Have you ever had any of the following? Please check all that apply:

- ☐AIDS
- ☐Alcohol Addiction
- ☐Alzheimer's Disease
- ☐Anemia
- ☐Angina
- ☐Arthritis
- ☐Artificial Joints
- ☐Artificial/Leaky Heart Valve
- ☐Asthma
- ☐Blood Disease
- ☐Blood Transfusion
- ☐Bruise Easily
- ☐Cancer
- ☐Chemotherapy
- ☐Cold Sores/Fever Blisters
- ☐Contact Lenses
- ☐Convulsions
- ☐Cortisone Medication
- ☐Diabetes
- ☐Diet: (Special/ Restricted)
- ☐Dizziness
- ☐Drug Addiction
- ☐Emphysema
- ☐Epilepsy
- ☐Excessive Bleeding
- ☐Excessive Thirst
- ☐Fainting
- ☐Frequent Cough
- ☐Glaucoma
- ☐Growths
- ☐Hay Fever
- ☐Headaches
- ☐H. I. V. Positive
- ☐Head Injuries
- ☐Heart (Attack, Disease, Surgery)
- ☐Heart Murmur
- ☐Hemophilia
- ☐Hepatitis – A B C
- ☐Herpes
- ☐High Blood Pressure
- ☐Hives or rash
- ☐Hypoglycemia
- ☐Irregular heartbeat
- ☐Jaundice
- ☐Kidney Disease
- ☐Latex Sensitivity
- ☐Leukemia
- ☐Liver Disease
- ☐Mental/Emotional Disorders
- ☐Mitral Valve Prolapse
- ☐Nervous Disorders
- ☐Pacemaker
- ☐Psychiatric/ Psychological Care
- ☐Pregnancy: Due date: _____
- ☐Radiation Treatment
- ☐Respiratory Problems
- ☐Rheumatic Fever
- ☐Rheumatism
- ☐Sinus Problems
- ☐Smoke/Chew Tobacco
- ☐Stomach Problems
- ☐Stroke
- ☐Thyroid Problems
- ☐Tuberculosis
- ☐Tumors
- ☐Ulcers
- ☐Venereal Disease
- ☐Codeine Allergy
- ☐Penicillin Allergy
- ☐**Do you pre-medicate with antibiotics prior to dental visits? ___ Yes ___ No**

Height: _____

Weight: _____

Are you Allergic to any of the following (please circle):

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other allergies? If yes, please explain: _____

Are you taking an Aspirin a day? _____ Are you taking Blood Thinners? _____

Have you been admitted to a hospital or needed emergency care during the past two years? _____ Yes _____ No

If yes, please explain: _____

Do you see a physician regularly (annual physical/exams)? _____ Yes _____ No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need clarification? _____ Yes _____ No

If yes, please explain: _____

Are you taking any medications? Purpose? Please list _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Dr. Pablo Cuevas 111 Beach Rd Fairfield, CT 06824

Please Handle Me with Care!

Name_____Date_____

Put a checkmark on the line next to the statement(s) that concern or describe you. Please bring this form along with you to your dental appointment.

_____ I gag easily.

_____ I feel out of control while I'm lying down in the dental chair.

_____ I have not been to a dentist for a long time and I am worried about what you will tell me about my teeth and my dental hygiene.

_____ I am embarrassed about the way my teeth look.

_____ I have had a bad dental experience and have a lot of fear that has kept me from getting the dental care I need.

_____ I am very apprehensive about the possibility of experiencing any pain. Therefore, pain relief is a top priority for me.

_____ Please tell me what I need to know about my mouth so that I can make informed decisions.

_____ I want to be able to ask as many questions as necessary so that I understand why and what treatment is being recommended for me.

_____ I have difficulty listening and remembering when I am in the dental chair.

_____ I would like to see pictures and videos that will help me understand my dental problems and their solutions.

_____ Please respect my time. I don't want to be left sitting in the reception area.

Other_____

_____

_____

Dr. Pablo Cuevas 111 Beach Rd Fairfield, CT 06824

Dental Health and Cosmetic Appearance

What is your biggest dental problem? _____

_____

_____

How has it affected you personally? _____

_____

_____

What do you see happening with your teeth over the next 10 years? _____

_____

_____

Ideally, what condition do you want your mouth to be in? And what would that look and feel like:

_____

_____

Date of last dental visit? _____

What is your primary concern that you would like us to address first? _____

When would you like to start treatment? _____

Are you currently in Pain? _____Yes _____No

Have you ever had any serious problem associated with previous dental treatment or dental emergencies?
_____Yes _____ No If Yes - please explain:

_____

_____

Your current dental Health is: _____Good _____Fair _____Poor

Do you now or have you had any pain/discomfort in your jaw joint (TMJ)? _____Yes _____No

When was your last dental cleaning: _____

How many times do you: floss/week? _____ Brush/week? _____

Do you avoid brushing any areas of your mouth because of tenderness? _____Yes _____No

Do you like your smile? __Yes __No would you like your teeth to be whiter? ___Yes ___No

Rate your smile from 1-10 (1 = hate it and 10 = Love it) _____

Is there anything you would like to change about your smile? ____Yes _____No

_____

_____

_____

FAIRFIELD SMILES BY DESIGN
COSMETIC AND IMPLANT DENTISTRY

Consent for Services and Financial Information

1. I hereby authorize Dr. Cuevas and/or his staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Cuevas to make a thorough diagnosis of my/my dependents' dental needs. Upon such diagnosis, I authorize Dr. Cuevas to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
2. I understand, acknowledge, and agree that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes. I further understand that my name or identifying information will be kept confidential.
3. Payment for services is due the day the services are provided. We have several payment options available to you, which we will be happy to discuss with you at your request. You understand that if payment is not made within thirty (30) days of the billing date that interest will accrue at a rate of 1.5% per month (18% annual rate) and you will be responsible for all interest charges.
4. As a courtesy, we will file your dental insurance on your behalf. However, you agree that knowing your insurance coverage is your responsibility. We are not responsible for incorrect information provided by your insurance carrier.
5. You agree that it is your responsibility to inform our office of any insurance and/or personal contact information. We are not responsible for insurance claims that are denied for timely filing because we did not receive your insurance information on a timely basis.
6. We cannot be responsible for interpreting your insurance policy terms and conditions, and we do not in any way guarantee insurance payment for any services.
7. We are not responsible for following up with your insurance company once we have filed the claim on your behalf. Any insurance payments not received within forty five (45) days are your responsibility. You also agree that you are responsibility for all amounts not paid by your insurance.
8. You agree that you or any person responsible for paying your bill must give 24-hour notice of appointment cancellation. If you fail to give proper notice, you hereby give consent to be billed for that time at the rate of 150.00 per hour.
9. If you or any person paying your bill issues a check to us that is returned for insufficient funds, you agree to be responsible for a returned check charge of twenty-five dollars ($ 25.00). You also understand that if you do not make replacement payment in full of the NSF check within ten (10) days, that we will pursue all civil and criminal remedies available to us to collect the full amount of the NSF check, and that you will be responsible for all costs of collection.
10. It is also agreed that upon your failure to pay any invoice when due, we may place your account with an attorney or a collection agency for collection. You hereby agree to pay all costs of collection, including but not limited to commission for collection agency, interest at 18% per annum, reasonable attorney's fees and court costs.
11. If your account is referred to a collection agency or an attorney due to non-payment, you hereby acknowledge and agree that such collection agency or attorney may obtain credit information about you from any source, including, without limitation, consumer credit reporting agencies, employers, and banks. Additionally, in the case of default, you also understand that your information may be reported to credit reporting agencies.
12. If your account is referred to a collection agency or an attorney due to non-payment, you hereby agree that you have been advised and give permission to be contacted using any and all of the contact information provided in this registration form.

Signature_____ Date_____

Printed Name_____

Dr. Pablo Cuevas 111 Beach Rd Fairfield, CT 06824

Insurance Information

Please present your insurance card(s) to the receptionist for copying.

Name of insurance policy holder:

_____

Is insured a patient? ____ Yes ___ No Birth Date: _____/_____/_____

Social Security # of policy holder _____/_____/_____

Patient's relationship to insured: ____ Self ____ Spouse ____Parent ____ Other (specify) _____

I, the undersigned, certify that I (or my dependent) have insurance coverage and I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Print Name_____Date_____

Fairfield Smiles by Design
Dr. Pablo Cuevas

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature_____Date_____

Print Name_____

Release of Information

I authorize the release of information including the examination, diagnosis, and records rendered to me and claims/account information to my family member(s):

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

_____**Information is not to be released to anyone.**

May we leave detailed information on your cell phone? _____Yes _____No

May we leave detailed information on your home answering machine? _____Yes _____No

May we send appointment reminders via email? _____Yes _____No

For office use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgment

___ An emergency situation prevented us from obtaining acknowledgment

___ Other (please specify)

_____

_____