PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

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

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Patient Signature:_____ Date:_____

MEDICAL HISTORY

Patient Name: _____ Nickname: _____ Age: _____
Name of Physician/and their specialty: _____ Phone #: _____
Most recent physical examination: _____ Purpose: _____
What is your estimate of your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

DO YOU HAVE or HAVE YOU EVER HAD	YES	NO
1. Hospitalization for illness or injury _____	☐	☐
2. An allergic reaction to: **(Circle)**_____	☐	☐
Aspirin Ibuprofen Acetaminophen		
Codeine Penicillin Erythromycin		
Tetracycline Sulpha Local anesthetic		
Flouride Metals (nickel, gold, silver) Clindamycin		
Valuim or other sedatives Latex		
3. Are you taking any of these Medications? **(Circle)** _____	☐	☐
Tagamet® (cimetidine) Prilosec® (omeprazole)		
Cardizem® (diltiazem) Calan, Isoptin® (Verapamil)		
Pre-medication before dental treatment		
Serzone® (nefazodone) Dilantin® Tegretol		
Barbiturates (any) Biaxin® (clarithromycin)		
St. John's Wort, Kava-Kava		
P 4. Heart problems or cardiac stent within the last six months	☐	☐
5. History of infective endocarditis _____	☐	☐
6. Artificial heart valve, repaired heart defect _____	☐	☐
P 7. Pacemaker, implantable defibrillator _____	☐	☐
8. Artificial replacement joints (Year?)_ _____	☐	☐
9. Rheumatic or scarlet fever _____	☐	☐
P 10. High or Low blood pressure (circle) Your normal BP=____	☐	☐
11. A stroke _____	☐	☐
12. Anemia or other blood disorder _____	☐	☐
13. Prolonged bleeding due to slight cut (INR>3.5) _____	☐	☐
14. Emphysema, sarcoidosis _____	☐	☐
15. Tuberculosis _____	☐	☐
16. Asthma _____	☐	☐
17. Breathing, Sleeping problems, Snoring, Sinus (circle)____	☐	☐
18. Kidney disease _____	☐	☐
19. Liver disease _____	☐	☐
20. Jaundice _____	☐	☐
21. Thyroid, Parathyroid disease (circle) _____	☐	☐
22. Hormone deficiency _____	☐	☐
23. High cholesterol, taking statin drugs (circle) _____	☐	☐
P 24. Diabetes (HbA1c) _____	☐	☐
B 25. Stomach, duodenal ulcer (circle)_____	☐	☐
B 26. Digestive disorders, Gastric/acid reflux _____	☐	☐

	YES	NO
27. Osteoporosis/Osteopenia	☐	☐
28. Have you been treated w/ Bisphosphonate drug's? (circle)	☐	☐
(Fosamax®, Aredia®, Zometa®, Actonel®, Boniva, RANKL, Denosumab, Prolia)		
P 29. Arthritis _____	☐	☐
30. Glaucoma_____	☐	☐
31. Contact lenses _____	☐	☐
32. Head or neck injuries _____	☐	☐
33. Epilepsy, convulsions (seizures) _____	☐	☐
34. Neurologic problems (attention deficit disorder)_____	☐	☐
35. Viral infections and cold sores _____	☐	☐
36. Any lumps or swelling in the mouth _____	☐	☐
37. Hives, skin rash, hay fever(circle) _____	☐	☐
38. Venereal disease _____	☐	☐
39. Hepatitis (type ____) _____	☐	☐
40. HIV / AIDS _____	☐	☐
41. Tumor, abnormal growth _____	☐	☐
B 42. Radiation therapy _____	☐	☐
B 43. Chemotherapy _____	☐	☐
P 44. Emotional problems _____	☐	☐
45. Psychiatric treatment _____	☐	☐
B 46. Antidepressant medication _____	☐	☐
BP 47. Alcohol, Drug dependency (circle) _____	☐	☐
48. Please provide current weight: _____		
ARE YOU:		
49. Presently being treated for any other illness _____	☐	☐
50. Aware of a change in your general health _____	☐	☐
51. Taking medication for weight management (fen-phen)	☐	☐
52. Taking dietary supplement _____	☐	☐
53. Often exhausted or fatigued _____	☐	☐
54. Subject to frequent headaches _____	☐	☐
P 55. A smoker or smoked previously (circle) _____	☐	☐
56. Considered a touchy person _____	☐	☐
57. Often unhappy or depressed _____	☐	☐
58. Consume grapefruit juice, grapefruits or grapefruit extract?	☐	☐
59. MALE – prostate disorders: _____	☐	☐
60. FEMALE – Taking Birth Control pills _____	☐	☐
61. FEMALE – Pregnant _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____ _____

List all medications, supplements, and or vitamins taken in the last two years

Drug	Dosage	Purpose	Drug	Dosage	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

3/4/2011

- Dental History -

TO HELP US PROVIDE A THOROUGH EXAM, PLEASE COMPLETE THIS TO THE BEST OF YOUR ABILITY. THANK YOU☺

On a scale of 1-10, how important is your dental health to you?_____ How would you rate your dental health(1-10)?_____
Who referred you?_____ Previous Dentist: _____ How long were you with your prior dentist? _____years.
Last dental exam: _____(months/years) ago. Last x-rays: _____(months/years) ago. Last treatment: _____(months/years) ago.
I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ I do not go routinely

WHAT IS YOUR IMMEDIATE OR MAIN CONCERN TODAY? _____

PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING. *HELPFUL COMMENTS ARE ENCOURAGED FOR THE "YES" ANSWERS:*	**YES**	**NO**
PERSONAL HISTORY Risk: Low o Mod o High o		
Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10(most)_____	☐	☐
Have you ever had complications or an unfavorable dental experience? _____	☐	☐
Have you ever had trouble getting numb or reactions to local anesthetic? _____	☐	☐
Have you had any teeth removed? _____	☐	☐
Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
On a scale 1-10, what is the current level of stress in your life? _____		
GUM AND BONE Risk: Low o Mod o High o	**YES**	**NO**
Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____	☐	☐
Have you ever experienced gum recession (gums shrinking around teeth)? _____	☐	☐
Have you ever had any teeth become loose on their own (without an injury)? _____	☐	☐
Is there anyone in your family with a history of periodontal gum disease? _____	☐	☐
Do your gums bleed or are they painful when brushing, flossing or eating? _____	☐	☐
Do you have difficulty eating an apple due to loose teeth? _____	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
Have you ever or currently smoke tobacco? (circle one)_____	☐	☐
Have you experienced a burning sensation in your mouth? _____	☐	☐
TOOTH STRUCTURE Risk: Low o Mod o High o	**YES**	**NO**
Do your parents or siblings have "bad teeth"? _____	☐	☐
Have you had any cavities within the past 3 years? _____	☐	☐
Does the amount of saliva in your mouth seem too little (dry mouth) or do you have difficulty swallowing any food?_____	☐	☐
Are any teeth currently sensitive to hot, cold, biting or sweets or do you avoid brushing any sensitive teeth?_____	☐	☐
Do you frequently snack on high sugar food/drinks throughout the day (soda, candy, cookies)? _____	☐	☐
Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____	☐	☐
Do you frequently get food caught between specific teeth and find it to be nuisance or problematic? _____	☐	☐
Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
Have you ever had a habit of sucking on lemons or eating a lot of citrus? _____	☐	☐
Do you drink high acidic beverages-on a daily basis (coffee, tea, lemonade, orange juice, soda, wine, power drinks)? _____	☐	☐
Have you ever experienced gastric acid reflux (acid coming up from stomach into your mouth, sour taste)? _____	☐	☐
Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
BITE AND JAW JOINT Risk: Low o Mod o High o	**YES**	**NO**
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? _____	☐	☐
Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	☐	☐
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars or other hard foods, dry foods? ___	☐	☐
Have your teeth changed in the last 5 years, such as become shorter, chip, thin out or worn? _____	☐	☐
Are your teeth becoming more crooked, crowded or overlapped? _____	☐	☐
Are your teeth developing spaces or becoming loose? _____	☐	☐
Do you have more than one bite, squeeze or shift to make your teeth fit together? _____	☐	☐
When bringing your teeth together, do you find that you have to search for a comfortable bite? _____	☐	☐
Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
Do you have pain or soreness in the muscles of your face? Where? When? _____	☐	☐
Do you chew ice, bite your nails, or use your teeth to hold objects or have any abnormal oral habits? _____	☐	☐
Do you clench your teeth in the daytime or make them sore? _____	☐	☐
Do you grind your teeth? _____	☐	☐
Do you have problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____	☐	☐
Do you or have your ever worn a bite appliance (Niteguard, Splint) ? _____	☐	☐
SMILE CHARACTERISTICS Risk: Low o Mod o High o	**YES**	**NO**
What is the most important thing to you about your smile? _____		
Have you been disappointed with the appearance of previous dental work? _____	☐	☐
Have you ever bleached (whitened) your teeth? _____	☐	☐
Have you felt unhappy, uncomfortable or self-conscious about the appearance of your teeth? _____	☐	☐
Is there anything about the appearance of your teeth that you would like to change? What? _____	☐	☐
Would you like to address any of your cosmetic concerns at this time? (Is the timing good?) _____	☐	☐

Patients Name: _____ **Patients Signature:** _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

YOUR RISK ASSESSMENT & SUSCEPTIBILTY PROFILE

Patient Name _____ Date _____

	Low	Moderate	High
GUM & BONE (Periodontal)			
TOOTH STRUCTURE (Biomechanical)			
JOINT (TMJ), BITE AND CHEWING (Functional)			
SMILE CHARACTERISTICS (Dentofacial)			

We would like to thank you for choosing our practice to provide your dental care. We are interested in providing a long-term strategy for *dental health.* We will strive to restore your mouth to proper form, function, comfort, esthetics and health. This risk assessment & susceptibility profile will allow you to identify and understand the 4 categories that are evaluated. An individualized custom-tailored health plan will always be proposed based on managing your risk & susceptibility. Rest assured, we are committed to taking great care of you. To help you understand, below you will find a description of the 4 categories evaluated.

WHAT DO THESE DOTS MEAN?

They represent your risk & susceptibility in each of the 4 categories. This risk is based on evidence-based research and Dr. Mirelez's clinical experience. Our objective is to minimize risk (shift towards the "green dot") and improve your dental health.

= you are at low risk

= you are at moderate risk

= you are at high risk

GUM & BONE (Periodontal)

This category evaluates the risk & susceptibility involved with your gum and bone (periodontal) health. Bone and gum is the foundation of our teeth that helps to support them. If you have a history or are currently experiencing gum and bone loss around your teeth, you are at risk for loosing more since periodontal disease is episodic and infrequent. Periodontal disease is affected by genetic factors (eg, inherited), environmental factors (eg, smoking, hygiene), and acquired factors (eg, stress, systemic disease) and has been shown to be associated to diabetes, adverse pregnancy outcomes, and cardiovascular disease. Your risk is based on: history and/ or current bone loss, severity of bone loss, bleeding gums, swollen gums, loose teeth, receeding gums, and/or missing teeth due to bone loss.

TOOTH STRUCTURE (Biomechanical)

This category evaluates the risk & susceptibility involved with your teeth structure. Teeth need to be healthy to be strong. If you have a history of cavities (caries, decay) or cracks, teeth are at risk for more problems. So, your risk is based on: history and/or current cavities, defective fillings/crowns, structurally compromised (large fillings) teeth, history of root canal treatment, erosion, and/or missing teeth due to tooth structure failure.

JOINT (TMJ), BITE AND CHEWING (Functional)

This category evaluates the risk & susceptibility involved with your joint, bite and chewing mechanism. Wear on teeth that doesn't correlate with age is a risk for future joint, bite and chewing problems. The joint is evaluated for noises and sounds, which may correlate to possible TMJ disorders. Your risk is based on: history and/or current TMJ disorder, pain/ difficulty with chewing, wear on teeth, an uneven bite, wedged out cavitations on side of teeth, loose teeth, and/or missing teeth that worsen the chewing mechanism.

SMILE CHARACTERISTICS (Dentofacial)

This category is based on your perception as our guide. It is also based on your current smile characteristics if alteration were going to be made. If teeth or gums are not in the correct position then changing your smile involves risk. Your risk is based on: your perception as a guide, tooth and gum position, tooth and gum length, lip position, teeth alignment and arrangement, and tooth color changes.

MIRELEZ WELLNESS DENTAL
HOLISTIC • AESTHETIC • SEDATION • IMPLANT
Total Solution & Health-Centered Dentistry

Three Levels of Dental Care

To our patients: Our primary goal is to develop a lifelong relationship with you and your family which enables us to provide high quality dental care in a personalized and comfortable manner. It is our goal to respect your wishes and help you become as healthy as you would like to be. Please review the levels of dental care we provide below and select the one that best describes the level of care that meets your current needs. Even though finances may be a concern, don't let it influence your decision. We know that things in life change, so you are welcome to change your level of care at any time in the future.

☐ **Level 1 - Immediate/Limited Care**

Patients who select this level of care desire treatment only when "something breaks" and becomes uncomfortable and/or painful. Generally, patients at this level prefer limited care and can expect "short-term" solutions. They usually want to correct immediate problems with as little effort as possible. Patients at this level are not yet ready for thorough or preventative treatment.

☐ **Level 2 - Maintenance Care**

Patients who select this level of care want to take an active part in the prevention of present and future disease problems, but choose repair solutions that are "medium-term". Patients in this level know full well that the dental treatment performed today may need to be repeated again in 2-5 years.

☐ **Level 3 - Optimum Complete Care**

Patients who select this level of care want to take a significant role in lowering their risk for dental problems and prefer all necessary treatment to be completed in order to minimize the amount and cost of dentistry needed in their lifetime. Optimum care patients want a comprehensive examination and a master plan to provide ultimate long-term health and wellness. Patients in this level want to achieve optimal oral health by proactive and preventative means.

Patient Name (Please Print): _____

Patient Signature: _____ **Date:** _____

J. Art Mirelez Jr., DDS, FICOI, FAGD
5492 N. Palm Avenue, Fresno, CA 93704 – Phone: (559) 435-3113 – Fax: (559) 435-5785
Email: DrMirelez@MirelezDental.com – Web: www. MirelezDental.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP).
This Notice describes how your medical information may be used and disclosed by us.
It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.
If you have any questions about this Notice, the name and phone number or our contact person is listed on this page.

Effective Date of this Notice	**October 1, 2003**
Phone Number	**(559) 435-3113**

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's ***NOTICE OF PRIVACY PRACTICES*.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this ***NOTICE OF PRIVACY PRACTICES*** should it be amended, modified, or changed in any way."

_____

Patient or Representative Name (Please Print)

_____ _____

Patient or Representative Signature **Date**

☐ Patient refused to sign ☐ Patient was unable to sign because _____

Financial Interest Disclosure

Under California law, I (Dr. Mirelez) am required to inform you, that I have a financial interest in **Dental Imaging Solutions,** to which I may refer you for services. There may be other organizations from which you may obtain these services. Should I decide to refer you to **Dental Imaging Solutions,** you should know that there may be alternative locations to acquire similar requested services.

Acknowledgement of Publicity Materials

[ ] **I authorize** the taking of clinical photographs and videos and their use for scientific, educational and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold Mirelez Wellness Dental harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

[ ] **I do NOT authorize** Mirelez Wellness Dental to take or share photographs and/or videos.

_____

Signature **Date**

J. ART MIRELEZ JR., DDS, FICOI, FAGD
5492 N. PALM AVENUE • FRESNO, CA 93704 • **PHONE:** 559.435.3113 • **FAX**: 559.435.5785
EMAIL: DRMIRELEZ@MIRELEZDENTAL.COM • **WEB:** WWW.MIRELEZDENTAL.COM

MIRELEZ WELLNESS DENTAL

OnCall Dental & URGENT CARE
559.900.2332
OnCallDentalFresno.com

Financial Policy

To maintain operations and prevent potential misunderstandings, we ask you to accept and adhere to the following financial policy for dental treatment for yourself or any family member:

PATIENTS WITH DENTAL INSURANCE:

We understand that dental insurance plays a role in helping defray some of the costs of dental care. However, we would like to share with you the following facts about dental insurance.

Dental insurance often will not pay for everything. It is meant only to **assist** in paying for your dental care. Dental insurance plans have no correlation to actual patients' needs. As such, many routine and necessary dental services are not covered, even though you may need those services. Our responsibility is to provide you with the best care and treatment to meet your needs, not to match your care to insurance plan limitations. Many plans pay much less than you might expect. The benefits your plan pays for are largely determined by how much your employer or you pay in premiums for the plan. We are happy to submit your claims and help you to receive the maximum benefits due to you, but please understand that **we do not accept responsibility for collecting an insurance claim, or negotiate disputed claims. *You remain responsible for payment for unpaid services.***

OPTIONAL PAYMENT TERMS:

- **Discount for Cash (no insurance):** We also provide a **5%** discount for restorative dental services when paid with cash, ***orthodontic and cosmetic treatment excluded***
- **In-Office Complete Dental Plan:** The complete dental plan (VIP) includes two complimentary cleanings, all exams and x/rays within the plan year, and you will receive a **10%** discount for restorative dental services. (Please note that discount will differ if financing is utilized) ***orthodontic and cosmetic treatment excluded***
- **Term Loan:** By arrangement with *some of our Finance companies,* we offer our patients an interest-free term loan with no down payment, no annual fee, and no prepayment penalty (subject to approval). You can complete the provided "*Payment Plan Credit Application*" . We have many different options for payments through our finance companies. Ask and we can send you our pre-qualification links. You can find additional information at **www.Mirelezdental.com.**

APPOINTMENT FEE:

For each appointment, a specific amount of time and material is reserved especially for you. We strongly encourage our patients to keep their appointments. If you must change your appointment, we require a **48 business hour notice. Appoint fees depend on appointment type:**

- **Hygiene appointments:$100 per hour.**
- **Dr. Appointments:$200 per hour.**
- **Sedation appointments: $1000.00.(Sedation appointments REQUIRE 7 day advance notice.)**

CONFIRMATION POLICY: We routinely confirm appointments via phone and or text. If we are unable to reach you,we may remove your appointment from the schedule and ask you to reschedule

COLLECTION POLICY:

We accept cash, debit cards, and all major credit cards. You will be responsible for a $75.00 bookkeeping fee if your account is assigned to a third party for collection. Should suit be commenced to enforce any of the terms of this agreement, you shall pay all attorney's fees and costs. The Court of jurisdiction shall be Fresno County. You hereby grant the right to verify employment or run a credit report to assess your ability to fulfill your financial obligation to this agreement. If communication by phone is necessary, you grant permission to the office, or our assigns, to contact you by phone. If you are unavailable, and a recording device is operable, a message may be left providing a name and phone number.

Patient Name (Please Print)_____ Patient Signature_____

Date _____