Rovi Smile Center

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First MI (Nickname)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Mobile): _____

Occupation: _____ E-MAIL Address _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have your ever had any of the following? Please check those that apply:

☐ AIDS
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Allergy to other medications_____
_____
☐ Heart Disease
☐ Mitral Valve Prolapsed
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Excessive Bleeding

☐ Artificial Joints
☐ Diabetes
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Dizziness
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Growths

☐ **Halitosis/Bad Breath**
☐ Hay Fever
☐ Head Injuries
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems

☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Scarlet Fever
Other: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you currently taking any medications ? ☐ Yes ☐ No If so, which ones?_____
  _____
- Have you ever taken the drug Plavix ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

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 doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐ Dental Office ☐ Yellow Pages
☐ Internet ☐Facebook ☐ School ☐ Work ☐ 1800Dentist

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

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Rovi Smile Center
Daniel A. Rovirosa, DMD

Dear Valued Patient,

The American Dental Association endorses a program for the detection of periodontal disease. Our hygienist is a specialist in this area. Our examination procedure includes a process for early detection of gum disease. Early detection makes it easier to treat and control. Our hygienist will begin by examining your gums. She will gently use a ruler type instrument to measure any pockets that may exist between the tooth and gum, screen for inflammation and bleeding. If she discovers areas in the mouth which are tender or bleeding then this usually indicates less than healthy tissue.

Upon completion of the exam, the hygienist will put you in one of five ADA categories:

0 Healthy Mouth
1 Gingivitis
2 Early Periodontitis
3 Moderate Periodontitis
4 Advanced Periodontitis

Any classification other than a category 0 will take you out of the Healthy category and therefore a regular cleaning is not possible. This may change what your insurance covers.

Fortunately for our patients, Healthcare is constantly improving techniques and procedures in order to prevent and treat our patients properly and avoid surgery or possible tooth loss. Unfortunately, some insurance companies/employers are not keeping up with the improvements
and are not covering certain procedures.

We, as your concerned providers understand this and will work with you as much as possible. Your oral health is important to us and we want to provide you with the absolute best treatment
necessary.

Please feel free to discuss any questions or concerns about your insurance with the front office
staff members, and any questions or concerns about your diagnosis with our hygienist.

Sincerely,

Daniel A. Rovirosa , D.M.D. Signature:_____ Date:_____

Rovi Smile Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have read this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____

Person we can speak to about your dental information: _____

_____

Rovi Smile Center

New Patient Consultation & Interview

Patient's Name _____ Date of Initial Visit _____

What is important to you?

_____

_____

What do you see with your smile?

_____

_____

What would you like to see with your smile?

_____

_____

Do you see yourself keeping your teeth for the rest of your life?

_____

_____

How do you feel about going to the dentist?

_____

How frequently have you gone to the dentist?

_____

When was your last visit to the dentist, and for what purpose?

_____

Have you had any bad past dental experiences?

_____

What are your objectives regarding your dental health (Function or Cosmetics)?

_____

What dental problems are you currently experiencing and how do these problems affect you?

_____

_____

How is your parents' dental health?

_____

How often do you brush your teeth and how often do you floss?

_____

Do your gums bleed when you brush and floss? _____

Regarding Finances

What is most important to you regarding finances?

_____

Do you like to get the money out of the way and pre-pay with a savings?

_____

If you are planning on a lot of treatment, what is your monthly budget?
_____

X_____ Date _____