

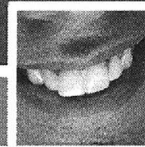
The Dental Studio

Maribel C. Carbia D.M.D.

4100 Salzedo St # 20

Coral Gables, FL 33146

(305)666-0006



Welcome to our Practice

Chart #.
FOR OFFICE USE ONLY

Patient Name:
Last First MI Preferred Name

Title: Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc

Birth Date: SS #: Prev. Visit:

Email Address: Best time to call:

Phone:
Home Work Ext Mobile Fax Other

Address:

City State Zip Code

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

Employer Name: Phone:

Address:

City State Zip Code

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

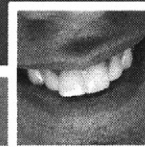
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When confirming appointments form of communication do you prefer?

☐ Phone call

☐ Text message

☐ E-mail

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> * Epilepsy | <input type="checkbox"/> * | <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Amox |
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Hay Fever |
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa |
| <input type="checkbox"/> Allergy to EPI | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | |

Signature: _____

Date:

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- | | |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury) | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Taking medication for weight control (ie fen-phen) | <input type="checkbox"/> Taking dietary supplements |
| <input type="checkbox"/> Subject to frequent headaches | <input type="checkbox"/> A smoker or smoked previously |
| <input type="checkbox"/> FEMALE: Taking birth control pills | <input type="checkbox"/> FEMALE: Pregnant |

If any condition or alerts selected above needs further clarification, please explain below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of physician and their specialty:

Most recent physical exam and purpose:

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 within the last two years:

I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Signature: _____

Date:

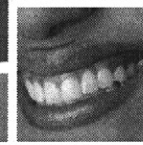
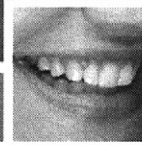
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Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long you have been a patient there:

Date of most recent dental exam:

Date of most recent dental x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

Personal History, Check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Had an unfavorable dental experience | <input type="checkbox"/> Had complications from past dental treatment |
| <input type="checkbox"/> Had trouble getting numb | <input type="checkbox"/> Had any reactions to local anesthetic |
| <input type="checkbox"/> Had/have braces, orthodontic treatment | <input type="checkbox"/> Had your bite adjusted |
| <input type="checkbox"/> Had any teeth removed | |

If any of the checked boxes need further explanation, please describe:

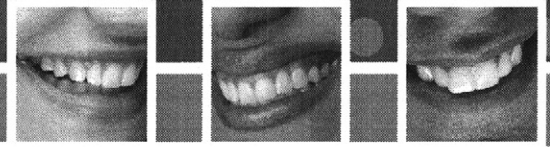
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Consent for Services and Financial Policy

We, the staff of The Dental studio thank you for choosing us as your dental/health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office at (305)666-0006.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, American Express and all major Credit Cards). Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Signature: _____

Date:

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Insurance Assignment of Benefits and Financial Responsibility

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

I authorize my insurance to pay my benefits directly to the dentist for all services rendered.

I authorize the use of this electronic signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges, whether or not paid by insurance.

I will be fully responsible for any outstanding balance on my account, including services denied as not medically necessary, when it is allowable under my plan and the provider contract for the provider to bill for the ineligible fee

Signature: _____

Date:

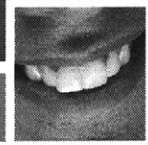
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HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPAA Disclosure Form.

Signature: _____

Date:

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Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Signature: _____

Date:

* ☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

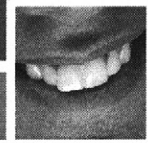
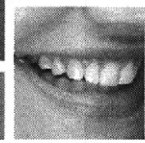
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The Dental Studio provides patients one on one time with Dr. Carbia and hygienist. It's very important that you keep your appointment. As a courtesy we call you and remind you of your appointment. If you are unable to keep your appointment please give a call 72 hours before your appointment to reschedule. If you cancel same day you will be charged a last-minute cancellation fee of \$75.00.

Signature _____

Response Date:

12/15/2018