Michelle Munoz, DDS
836 N. 4th St. Uvalde, TX 78801
(830) 278-4444
uvaldedentist.com

Patient Information

Date _____ Social Security # _____ Birthdate _____

Name _____ (Last Name) _____ (First Name) _____ (Initial) Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Email _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____

Primary Dental Insurance

Person Responsible for Account _____ (Last Name) _____ (First Name) _____ (Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____ (Last Name) _____ (First Name) _____ (Initial)

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

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Dental History

Former Dentist _____ Date of last X-Rays _____

City, State _____ How often do you floss? _____

Date of last dental visit _____ How often do you brush? _____

Please check all that apply:

Bad breath ☐	Loose teeth or broken fillings ☐	Sensitivity to sweets ☐
Bleeding gums ☐	Orthodontic treatment ☐	Sensitivity when biting ☐
Blisters on lips or mouth ☐	Pain around ear ☐	Frequent headaches ☐
Fingernail biting ☐	Periodontal treatment ☐	Jaw, head, or neck injuries ☐
Grinding teeth ☐	Sensitivity to cold ☐	Jaw difficulty: clicking and/or pain ☐
Lip or cheek biting ☐	Sensitivity to heat ☐	Tooth pain ☐

Medical History

		Yes	No
1.	Are you currently under treatment?	☐	☐
2.	Have you ever had any serious illnesses or operations?	☐	☐
3.	Are you currently taking any medications? Please describe: _____	☐	☐
4.	Do you smoke?	☐	☐
5.	Do you use alcohol, cocaine, or other drugs?	☐	☐
6.	Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following?	Yes	No
Local anesthetics (eg. Novocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other _____		

8. (Women only) Are you:		
Pregnant?	☐	☐
Nursing?	☐	☐
Take birth control pills?	☐	☐

Please check all that apply:

AIDS ☐	Chemical dependency ☐	Glaucoma ☐	Kidney disease ☐	Shortness of breath ☐	
Anemia ☐	Chemotherapy ☐	Headaches ☐	Liver disease ☐	Sinus trouble ☐	
Arthritis, rheumatism ☐	Chronic fatigue syndrome ☐	Heart murmur ☐	Low blood pressure ☐	Skin rash ☐	
Artificial heart valves ☐	Circulatory problems ☐	Heart problems ☐	Mitral valve prolapse ☐	Stroke ☐	
Artificial joints ☐	Congenital heart lesions ☐	Hepatitis-Type ____ ☐	Nervous problems ☐	Swelling of fee/ankles ☐	
Asthma ☐	Cortisone treatments ☐	Herpes ☐	Pacemaker ☐	Swollen neck glands ☐	
Back problems ☐	Cough- persistent or bloody ☐	High blood pressure ☐	Psychiatric care ☐	Thyroid problems ☐	
Bleeding abnormally, with extractions or surgery ☐	Diabetes ☐	HIV positive ☐	Radiation treatment ☐	Tonsillitis ☐	
	Emphysema ☐	Jaundice ☐	Respiratory disease ☐	Tuberculosis ☐	
Blood disease ☐	Epilepsy ☐	Jaw pain ☐	Rheumatic fever ☐	Tumor or growth on head/neck ☐	
Cancer ☐	Fainting or dizziness ☐	Latex sensitivity ☐	Scarlet fever ☐	Ulcer ☐	
				Venereal disease ☐	

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the sue of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This notice describes information about privacy practices by our office. The practices described in this notice will also be followed by the dentist and their staff in our office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health/dental information about you and also describes your rights and our obligations regarding the use and disclosure of your information.

This will include information and records we have about your health and the service you receive by us. We may use and disclose health/dental information about you for your treatment, payment and dental care operations.

The definition of using your health /dental information is when our office analyzes, examines, shares or applies your information, such as entering your information into our computer.

The definition of disclosing your health/dental information is when we release, transfer or allow it to be accessed and/or disclosed outside our practice. An example would be when we release information or charges to your insurance company for payment.

Under certain circumstances we may release your health/dental information without your permission. These include emergencies, identification of deceased, or cause of death, public health issues, research under specified guidelines with your authorization, health/dental care system oversight, judicial and administrative proceedings, requirements under law enforcement and requirements for national defense and security.

We may contact you as a reminder that you have an appointment at our office for your dental care unless we receive written notice from you that we may not. We may tell you about possible treatment options or dental healthcare products that may be of interest to you.

We may disclose health/dental information about you to your family members or friends based on our professional judgment that you would not object. An example of this would be if your spouse called to find out the date of your next appointment or a friend came by to pick up a prescription for you at our office. However, you have the right to limit disclosure, even to family members if you choose. You must notify our office in writing if you choose this option.

In situations where you are not capable of giving consent because you are not present or emergency, we will base our decision on our professional judgment.

We will not use or disclose your health/dental information for any purpose other than those listed previously without your written authorization.

You have certain rights regarding your dental information. You have the right to inspect and copy your dental information. You must submit a written request to our office in order to do so. We have ten (10) business days to comply with this request. If you request a copy of these records we may charge you a fee for the costs of copying or mailing in accordance with our state law. We have the right to deny your request to inspect or copy these records in certain limited circumstances. If you are denied this information, you have the right to ask for a review by a licensed health/dental care professional that we select.

If you believe that the dental information about you is incorrect or incomplete you have the right to ask us to amend the information. You must complete and amendment and submit to our office. We may deny your request if it includes information from another dentist or is accurate and complete.

You have the right to request and accounting of non-routing disclosures of your health/dental information. This would include a list of disclosures we made of your health/dental information for purposed other than treatment, payment and dental care operation. To receive a list, you must submit a written request. We may charge you for the cost.

We reserve the right to change this privacy notice. You may file a complaint with our office or the Sec. of the Dept. of Health and Human Service if you believe your privacy rights have been violated with no retaliation for filing the complaint.

SIGNATURE_____**DATE**_____