SKYVIEW DENTAL
FAMILY AND COSMETIC DENTISTRY

Erika Mendez, D.D.S.

1105 Kinwest Pkwy., Ste.102 • Irving , TX 75063 • 972.401.2054 • Fax 972.401.2351

Patient Information

Date: _____ Name: _____ ☐ ☐
Last First Middle Initial (Preferred Name) Male Female

Mailing Address: _____ E-mail address: _____
Number & Street or P.O. Box City State Zip

Date of Birth: _____ SSN: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Spouse or Person Responsible for Account

Name: _____ ☐ ☐ ☐ ☐
Last First Middle Initial (Preferred Name) MR. MRS. MS. DR.

Mailing Address: _____ Date of Birth: _____
Number & Street or P.O. Box City State Zip

Employer: _____ SSN: _____ Driver License Number: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Additional Information

Emergency Contact Person: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I Learned of your office by : ☐ Office Sign ☐ Internet ☐ Referral _____
Whom may we thank for referring you ?

Dental Insurance Information

Subscriber's Name: _____ Date of Birth: _____ SSN: _____
Last First Middle Initial

Subscriber's Address: _____
Number & Street City State Zip

Subscriber's Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Subscriber's Employer: _____ Work Phone: _____

Employer's Address: _____
Number & Street City State Zip

Name of Dental Insurance Company: _____ Insurance Phone: _____

Insurance Company Address: _____
Number & Street City State Zip

Insurance Group/Policy Number: _____ Insurance ID Number: _____

(Please note that we do not file secondary insurance.)

Please be sure to fill out the information requested on the other side of this form.

Medical History

Patient Name:

Patient DOB:

Please check any of the following medications you are taking.

- ☐ Blood thinners
- ☐ Cortisone
- ☐ Insulin
- ☐ Muscle relaxers
- ☐ Nerve medications
- ☐ Pain medications
- ☐ Stimulants
- ☐ Tranquilizers
- ☐ Other _____
- ☐ I am not taking any of these medications.

Please check if you have allergies or sensitivity to any of the following.

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Epinephrine
- ☐ Latex
- ☐ NSAIDS (Ibuprofen)
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other _____

☐ I have no medication allergies.

Please check any dental concerns you may have:

- ☐ Appearance of smile
- ☐ Bad breath
- ☐ Broken/chipped tooth
- ☐ Cavities
- ☐ Cosmetic concerns
- ☐ Denture problems
- ☐ Jaw discomfort/problems
- ☐ Lost/broken fillings
- ☐ Mouth sores
- ☐ Removable partial problems
- ☐ Sensitive teeth/gums
- ☐ Swollen/bleeding gums
- ☐ Teeth grinding
- ☐ Other _____

Bisphosphonates: Check if you have taken.

- ☐ Actonel*
- ☐ Araedia*
- ☐ Boniva*
- ☐ Fosomax*
- ☐ Zometa*
- ☐ Other _____

*These can stay in your system for 10 years or more. The dangers do not go away.

Women

Are you pregnant? Yes ☐ No ☐

If so, number of months: _____

Are you nursing? Yes ☐ No ☐

Taking birth control pills? Yes ☐ No ☐

Last dental visit _____

Times a day you brush _____

Times a week you floss _____

1. Have you been under the care of a medical doctor or in the hospital during the past two years? . . . . . Yes ☐ No ☐
   If yes, for what? _____
2. Have you taken any medications or drugs during the past two years? . . . . . Yes ☐ No ☐
3. Are you taking any medications, drugs, vitamins or pills now?. . . . . Yes ☐ No ☐
   If yes, please list the name(s), dosages and reason for usage on the separate Medication List Provided.
4. Do you require pre-medication (antibiotics) for dental procedures? . . . . . Yes ☐ No ☐ I don't know ☐
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? . . . . . Yes ☐ No ☐
   If so, please explain. _____
6. Do you use tobacco? Yes ☐ No ☐ What form? How much? How long?

Have you ever had or do you now have any of the conditions listed? (Each item must be marked.)

YES	NO	
☐	☐	Allergies: seasonal
☐	☐	Anemia
☐	☐	Anxiety
☐	☐	Arthritis/Rheumatism
☐	☐	Artificial heart valve
☐	☐	Artificial joints
☐	☐	Asthma
☐	☐	Back/Neck pain
☐	☐	Bleeding problems
☐	☐	Breathing problems
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Chest pains
☐	☐	Chronic cough
☐	☐	Cold sores
☐	☐	Diabetes
☐	☐	Chemical Dependency

YES	NO	
☐	☐	Dizziness/Fainting
☐	☐	Emphysema
☐	☐	Epilepsy or Seizures
☐	☐	Glaucoma
☐	☐	Growths/tumors
☐	☐	Head injury
☐	☐	Headaches (severe)
☐	☐	Heart attack/disease
☐	☐	Heart murmur
☐	☐	Heart pacemaker
☐	☐	Hepatitis/Liver disease
☐	☐	Herpes
☐	☐	High/low blood pressure
☐	☐	HIV+AIDS/ARC
☐	☐	Jaundice

YES	NO	
☐	☐	Kidney disease
☐	☐	Leukemia
☐	☐	Lupus
☐	☐	Psychiatric disorders
☐	☐	Radiation therapy
☐	☐	Rheumatic fever
☐	☐	Sexually transmitted disease
☐	☐	Shingles
☐	☐	Sinus problems
☐	☐	Stomach problems or Ulcers
☐	☐	Stroke
☐	☐	Swollen neck glands
☐	☐	Thyroid disease
☐	☐	Tuberculosis
☐		Other: _____

Would you like to complete a complimentary Invisalign scan today? Yes ☐ No ☐

I have answered all questions to the best of my knowledge. I will not hold Dr. Erika Mendez responsible for any errors or omissions I may have made. Should further information be needed you have my consent to ask the respective health care provider. I will notify the doctor of any changes in my health or medication.

Patient Signature (or guardian, if a minor): _____ Date: _____

SKYVIEW DENTAL
FAMILY AND COSMETIC DENTISTRY

Erika Mendez, D.D.S.

1105 Kinwest Pkwy., Ste. 102 • Irving , TX • 972.401.2054 • Fax 972.401.2351

Patient Medication List
Please print carefully your medications, vitamins or supplements.

Patient Name: _____ Date: _____

Medication	Dosage	Condition being treated	Start Date	Stop Date

Please make copies of this sheet if needed, for additional medications.

SKYVIEW DENTAL
FAMILY AND COSMETIC DENTISTRY

Erika Mendez, D.D.S.
1105 Kinwest Pkwy., Ste. 102 • Irving , TX 75063 • 972.401.2054 • Fax 972.401.2351

General Consent Form for Dentistry

Please read the following concerning your dental care, then sign and date this consent form. Feel free to ask your provider any questions you may have. In addition to this form, depending on your treatment, you may need to sign other treatment-specific form(s).

Medical History:

I have provided an accurate report of my physical and mental history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, blood or body diseases, gum or skin reactions or any other conditions related to my health.

Examinations and radiographs (x-rays):

I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan.

Changes in treatment plan:

I understand that, because of conditions found while working on the teeth, it may be necessary to change or add procedures to the treatment plan that were not discovered during the examination. I give my consent to the dentist or his assistant to consult with me about additional changes in the treatment plan.

Drugs, medication(s) and sedation:

I understand that antibiotics, analgesics and other medications can cause allergic reactions resulting in redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). I consent to the type of anesthesia deemed best by my doctor. I understand potential complications may include pain, swelling, infection, transient discoloration or numbness of the lip, tongue, chin, cheek or teeth. I understand that failure to take medications prescribed to me in the manner instructed may offer risks of continued or aggravated infection, pain or potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

Hygiene:

I understand that proper home care (regular brushing, flossing and other specific instructions) is essential, and that routine, professional cleanings and exams are necessary to maintain good oral health. I understand that without proper home care, even the best dental restorations cannot be expected to last.

Dentistry:

I understand that dentistry is not an exact science and therefore that reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist or corporate entity other than the treating dentist is responsible for my dental treatment.

Exposure Incidents:

I understand that in spite of universal precautions, accidents still occur. If a healthcare provider is exposed to my blood or body fluids (i.e., through a "stick"), I understand I may be asked to consent to my blood being tested in a confidential manner to ensure the proper care for the healthcare provider.

Patient Name (please print) _____

Patient Signature (or guardian, if a minor) _____ Date: _____

SKYVIEW DENTAL
FAMILY AND COSMETIC DENTISTRY

Erika Mendez, D.D.S.

1105 Kinwest Pkwy.,Ste.102 • Irving, TX 75063 • 972.401.2054 •Fax 972.401.2351

Business Policy

Dr. Mendez & staff are committed to providing you with the best dental care we possibly can. Additionally, it is important that you, as our patient, fully understand your treatment plan and the fees involved, as you contract for services with your dental care provider. **Our office policy requires that payment of fees be made in full at the time of treatment.** Any other arrangement for payment must be made in advance with the business manager. The following are accepted methods of payment.

- **Cash or check** - There is a service charge of $35.00 for returned checks.
- **Visa, Mastercard, American Express, Discover** credit cards
- **Care Credit** (for treatment of $300 or more; 12-months deferred interest if you qualify)
- **Assignment of insurance benefits:**

1. We cannot always predict the exact amount your insurance will pay, although we will estimate to the best of our ability the portion your insurance will cover. Although we are not in network with any carrier, other than Delta Dental, as a service we will file your insurance for you. *It is the decision of your insurance company what they will pay for your treatment. Ultimately, you are responsible for all the charges.*

2. We cannot accept responsibility for collecting your insurance claim. Therefore, if payment is not received from your insurance carrier within 30 days from the date of service performed, you are responsible for paying the balance owed. Account balances over 90 days are subject to being turned over to a collections agency unless arrangements to settle the account are made.

3. Your signature below indicates your willingness to assign all dental benefits to which you (or your dependents) are entitled, to Dr. Erika Mendez. Please understand that you are responsible for any amount not covered by your insurance.

Regarding appointments, our policy is that Dr. Mendez & staff will, to the best of their ability, see you as close to your appointment time as possible. This time is blocked off for you, in order that you may receive specific attention from our providers. If you do not show for your appointment, there will be a $50.00 charge. Our policy is:

- If you are **twenty minutes late**, we will have to reschedule your appointment.
- If you need to reschedule an appointment, please give us 24 hours prior notice.
- If you miss two scheduled appointments without having given a 24-hour prior notice, we will not schedule future appointments, and a $50.00 charge.
- If you have an overdue account, we will not see any member of your immediate family until the account is settled.

Your signature below signifies your acceptance of these terms.

Patient Name (please print) _____

Patient Signature (or Guardian if minor) _____ Date: _____

SKYVIEW DENTAL
FAMILY AND COSMETIC DENTISTRY

Erika Mendez, D.D.S.

1105 Kinwest Pkwy., Ste.102 • Irving , TX 75063 • 972.401.2054 • Fax 972.401.2351

Consent & Acknowledgment of Receipt of Privacy Notice (HIPAA)

I have been given a copy of Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices, and prior to implementation will mail a copy of the revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or healthcare operations and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information, and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Patient Name (please print) _____

Patient Signature (or guardian, if a minor) _____ **Date:**_____