Dr. Marcela Lezama D.D.S
General Dentist

747 Foothill Blvd. La Canada Flintridge, CA 91011
Phone # (818)790-1160
Email: romero-lezama-dds@outlook.com

ADULT GENERAL INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide you with the best dental services. To assist us, please complete the following form.

Patient name: _____
Date of birth: _____/_____/_____ Sex: (M) / (F) Age: _____

Driver's license #: _____SS #: _____/_____/_____
Employer/Occupation: _____Business Phone: ( )_____-_____

How were you referred to our office: _____

Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐

Home address: _____
City: _____ State: _____ Zip: _____

Email Address: _____

Billing address- IF DIFFERENT FROM ABOVE INFORMATION:

City: _____State: _____ Zip: _____
Home #: ( ) _____ Cell #: ( ) _____

If married please provide spouse contact information:
Spouse's name: _____Phone# :( )_____-_____
In an event of emergency who should we contact?
Relationship to self: _____
Emergency phone # ( ) _____-_____ Cell: ( ) Home: ( )
Conservator's Name for Patient: _____
Conservator' relationship to Patient_____

INSURANCE INFORMATION:

Subscriber's name: _____
Date of birth: _____ SS #: _____/_____/_____
Primary dental insurance: _____ Group #: _____
Secondary dental insurance: _____ Group #: _____
Name of your medical doctor: _____

Name of previous dentist: _____
Date of last visit to dentist: _____

MARCELA LEZAMA, D.D.S
PEDRO ROMERO, D.D.S

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ADULT HEALTH HISTORY

Patient Name_____ Date of Birth_____

Welcome to our office. Please fill out this short Health History form so we may be aware of any problems you may have or have had. Use the Additional Comments at the end of this form to include any additional information. Thank you.

Please circle ***YES*** or ***NO*** or fill in where appropriate:

Primary reason for this appointment_____
Name of your physician_____
Physician's address_____
Physician's phone number_____
Date of last visit to physician_____
Are you in good health?.....Yes/No
Has there been any change in your health since last year?.....Yes/No
Have you had any serious illness/operation/hospitalization within the past 5 years.....Yes/No
Are you taking any medicine(s) including non-Prescription?.....Yes/No
Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves, artificial valves or murmur.....Yes/No
b. Rheumatic Heart Disease.....Yes/No
c. Arteriosclerosis.....Yes/No
d. High blood pressure.....Yes/No
e. Heart trouble, heart attack, angina, or any other heart conditions.....Yes/No
    1. Chest pain on exertion?.....Yes/No
    2. Shortness of breath after mild exercise?.....Yes/No
    3. Do your ankles swell?.....Yes/No
f. Allergy i.e. foods, plants, latex, etc. .....Yes/No
g. Sinus trouble.....Yes/No
h. Asthma or hay fever.....Yes/No
i. Fainting spells or seizures.....Yes/No
j. Diabetes.....Yes/No
k. Hepatitis, jaundice or liver disease.....Yes/No
l. Frequent or recurring mouth sores.....Yes/No
m. Thyroid problems.....Yes/No
n. Respiratory problems.....Yes/No
o. Arthritis or painful swollen joints.....Yes/No
p. Stomach ulcer or hyperacidity.....Yes/No
q. Kidney trouble.....Yes/No
r. Tuberculosis.....Yes/No
s. Persistent cough or cough that produces blood.....Yes/No
t. Persistent swollen neck glands.....Yes/No

u. Epilepsy or neurological disorder……Yes/No
v. Problems with mental health……Yes/No
w. Cancer……Yes/No
x. Problems of the immune system……Yes/No

Have you had abnormal bleeding?……Yes/No
Have you ever required a blood transfusion?……Yes/No
Do you have any blood disorders such as anemia?……Yes/No
Have you ever had treatment for a tumor or growth……Yes/No
Are you allergic or have you had reaction to:

a. Local anesthetics……Yes/No
b. Penicillin or antibiotics……Yes/No
c. Sulfa drugs……Yes/No
d. Barbiturates or sleeping pills……Yes/No
e. Aspirin……Yes/No
f. Iodine……Yes/No
g. Codeine or other narcotics……Yes/No
h. Other……Yes/No

Do you now or have ever used tobacco products?……Yes/No
Have you had any serious trouble associated with previous dental treatment?……Yes/No
If so, explain_____
Do you have any other condition or diseases you think we should know about? But would prefer to discuss privately rather than writing them down?……Yes/No
Are you wearing contact lenses?……Yes/No
Are you wearing removable dental appliances?……Yes/No

FOR WOMEN ONLY:

*Are you pregnant?……Yes/No
*Do you have problems associated with your menstrual period ……Yes/No
*Are you nursing? ……Yes/No
*Are you taking birth control pills?……Yes/No

_____

ADDITIONAL MEDICAL INFORMATION

List any drugs your taking_____
List any drugs allergic to_____

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that proving incorrect information can be dangerous to my health. I acknowledge that my questions, if any, about the inquiries set forth above been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any error or omission that I may have made in the completion of this form.

X_____ _____
Signature of patient, parent or guardian **Date**

x_____ _____ _____
Additional History Update **Comments** **Date**

Dentist for Children
Pedro Romero, D.D.S

General Dentist
Marcela Lezama, D.D.S

Orthodontics
Limited practice
Patricia Valenzuela, D.D.S

OFFICE POLICIES AND FINANCIAL AGREEMENT

Thank you for choosing Dr. Romero and Dr. Lezama for your oral health care needs. Our team's expertise, and commitment to our patients ensures you will receive the best comprehensive care possible. We hope to develop and maintain a professional relationship that will strengthen through the years to come. During this time we will establish a financial relationship. In order to successfully maintain this relationships it is important that you have a clear understanding of our office policies. Please read, understand, and sign this policy statement.

INSURANCE-

We must emphasize that as dental health care providers, our relationship is with our patients, not the insurance companies. We are not part of your contract and cannot guarantee payments of all claims. If only a portion of your bill is paid by the insurance or a claim is rejected, any explanation will be provided to you by your insurance company. Reduction or rejection of your claim by your insurance does not relieve the patient of their financial obligations with the office. ***We are not responsible for how your insurance company processes claims, or what benefits are paid. For this reason we can only provide you with an "ESTIMATION OF YOUR INSURANCE COVERAGE AND BENEFITS"***. PPO insurance patient are required by your dental plan to pay all co- pays and deductibles at the time of visit. We do not balance bill payments owed to your home address. For your convenience we gladly accept Visa, Master card, Amex, Discover, Care Credit, Checks, and Cash payments

In order for us to bill your dental visit. You must submit ***Proof of current insurance coverage*** at the time of your reserved appointment. ***Without current proof of coverage, payment for your dental visit and all services will be required the day services are rendered.*** You may submit insurance information after the date of service, we will be glad to bill the insurance and refund your payment.

CANCELLATIONS-

A specific time is reserved when you schedule your appointment. We require patients to cancel appointments with at least 24 hour notice so we may reschedule the reserved time and offer this availability to another patient. We offer a one-time waived fee to our patients, as we understand that there may be personal conflict or illness. Any cancellations made after initial write off has been accessed, a broken appointment fee will automatically be applied to patients account. It is our policy to charge a fee of $ 25.00 per account for any appointment that has been scheduled in advanced and cancelled with less than a 24 hour notice. Cancelation of appointments made on the same day must be done with at least an hour of notice or the broken appointment fee will apply. Our automated system is designed to help you keep organized with your future appointments. With the provided email on file we will send out a confirmation email (2 weeks) before your scheduled visit. If we do not receive any response from the email. You will then receive a text message from the provided cell phone on file. Again, if there is no correspondence from the text message reminder. We will call as a courtesy the night before the scheduled appointment. If the office is closed and you are requesting to cancel your appointment, please leave a message on our after-hours answering machine phone number (818-790-1160) so we may notate your account. Or you may email us at dentistryforchildren@outlook.com. The broken appointment fee will not be applied if your message, or email is left before the required 24 hour notice to your scheduled appointment.

PEADATRIC PATIENTS & SCHEDULING-

We do encourage our younger patients to schedule for our early morning availability. This allows Dr. Romero the time to dedicate all his attention to any concerns, anxieties, or fears of the child may have. All dental treatment diagnosed will be scheduled Wednesday through Friday from opening till 2 pm. As we are extremely busy with routine hygiene visits in the after school hours we are unable to schedule treatment from 3pm to closing. Your child's dental appointment is an excused absences from school, and we do provide our patients with a school absence note, and work excused letters.

FINANCIAL REQUIREMENTS AND PAYMENTS FOR ALL PATIENTS-

- We have established the length of time that we will carry outstanding balances with our patients. Therefore***, prior credit card payment authorization for unpaid balances beyond 90 days from the date of services is now required.*** All current covered insurance will be submitted first. We will bill the credit card on file for any charges that exceed the 90 day mark. A $25.00 fee will be applied if credit card payment is declined for any reason. Please make sure that all credit card information given to the office remains valid at all times. Receipts for all charges made will be mailed to address on patients file.
- We are not in a position to mediate payment arrangements between separated parents or guardians. Any person accompanying the patient, or minor to the office will be financially responsible for any charges incurred. We do not balance bill payments to your home address. For your convenience we gladly accept Visa, Master card, Amex, Discover, Care Credit, Checks, and Cash payments.
- For our non-insurance patients a courtesy adjustment will be applied to treatment paid in full using cash only (excludes debit, and check) Details upon request.
- We request payment for first time appointments to the office be satisfied with cash, or by credit only. No checks will be accepted. We apologize if this causes any inconvenience. This is a short term arrangement.
- There will be a returned check fee of $ 12.00 for any insufficient funds received by the office. This fee will be added to the outstanding balance of your account.
- We do understand that financial hardships can affect timely payment of your account. If problems do derive. Please contact **once your first billing statement has been received**. We offer Care Credit, with credit approval. If care credit is not an option. We can set up a financial agreement in house. This allows us to agree upon a comfortable payment arrangement to pay for overdue payments, treatment, or patient portions for services provided.

By signing this agreement I acknowledge and understand the policies explained above pertaining to Dr. Romero and Dr.Lezama's dental practice.

(PRINT) name of Responsible Party: _____Date:_____