

<u>Dr. Marcela Lezama D.D.</u>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:				
Patient name:	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: Cell: () Home: ()			
Conservator's Name for Patient:				
Conservator' relationship to Patient				
INSURANCE INFORMATION:				
Subscriber's name:				
Date of birth: SS #:				
Primary dental insurance:				
Secondary dental insurance:				
Name of your medical doctor:				
Name of previous dentist: Date of last visit to dentist:				
Date of last visit to deficist.				

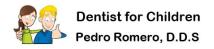


747 Foothill Blvd. La Cañada, CA. 91011 Ph. (818) 790-1160 Fax (818) 790-5603 Email: romero-lezama-dds@outlook.com

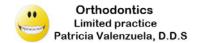
ADULT HEALTH HISTORY

Patie	nt Name Date of Birth	e 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.				
Pleas	e circle <i>YES</i> or <i>NO</i> or fill in where appropriate:			
	ry reason for this appointment			
	of your physician			
	vsician's address			
	sician's phone number			
	te of last visit to physician			
	ou in good health?			
	ere been any change in your health since last year?			
	you had any serious illness/operation/hospitalization within the past 5 years			
	ou taking any medicine(s) including non-Prescription?	Yes/No		
-	u have or have you had any of the following diseases or problems?	** (**		
a.	· · · · · · · · · · · · · · · · · · ·			
b.	Rheumatic Heart Disease			
C.	Arteriosclerosis			
d.	High blood pressure			
e.	Heart trouble, heart attack, angina, or any other heart conditions			
	1. Chest pain on exertion?			
	2. Shortness of breath after mild exercise?	•		
c	3. Do your ankles swell?			
f.	Allergy i.e. foods, plants, latex, etc.	•		
g.	Sinus trouble			
h.	Asthma or hay fever			
i.	Fainting spells or seizures			
j. 1-	Diabetes	•		
k.	Hepatitis, jaundice or liver disease			
l.	Frequent or recurring mouth sores			
m.				
n.	Respiratory problems			
0.	Arthritis or painful swollen joints			
p.	Stomach ulcer or hyperacidity	•		
q.	Kidney trouble	•		
r.	Tuberculosis			
S.	Persistent cough or cough that produces blood			
t.	Persistent swollen neck glands	res/No		

Additional History Update	Comments	Date
ыдписите ој ристепс, х		
XSignature of patient,	ngrent or quardian	 Date
may have made in the comple	uon oj tnis jorm.	
-	v dentist or any member of the staff responsib otion of this form	ne jor any error or omission that I
=	t my questions, if any, about the inquiries set	
	ly answered. I understand that proving incom	-
= =	understood the above information to the best	
Leastifuthat I have send and		a of many lymposis and an a The sub-sus-
List any drugs allergic to		
List any drugs your taking		
ADDITIONAL MEDICAL INFO		
*Are you taking birth contro	ol pills?	Yes/No
•	······································	
, , ,	ociated with your menstrual period	
·		Yes/No
FOR WOMEN ONLY:		
	e dental appliances?	
	nses?	
	n writing them down?	•
• • •	dition or diseases you think we should kno	www.about? But would prefer to
If so, explain	ouble associated with previous defital tre	163/ NO
•	rouble associated with previous dental tre	
	sed tobacco products?	·
_	ai Cotics	
	arcotics	
•		
	ping pills	
	ning pills	
	tics	-
		•
Are you allergic or have you		V /N -
•	nt for a tumor or growth	Yes/No
	orders such as anemia?	
	lood transfusion?	
•	eding?	-
x. Problems of the im	ımune system	Yes/No
		•
	ntal health	•
u. Epilepsy or neurol	ogical disorder	Yes/No







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.

and Dr.Lezama's dental practice.	
(PRINT) name of Responsible Party:	Date:

By signing this agreement I acknowledge and understand the policies explained above pertaining to Dr. Romero