WELCOME

Ivan E Vega, D.D.S.

We are pleased to welcome you and/or your child to our practice.
Please take a few minutes to fill out this form as completely as you can.
If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date: ______________________ Occupation: ______________________

SS/HIC/Patient ID #: ______________________ Patient Employer/School: ______________________

Patient Name: ______________________ Employer/School Address: ______________________

Address: ______________________ ______________________

City: ______________________ Employer/School Phone: ______________________

State: __________ Zip: __________ Spouse's Name: ______________________

E-mail: ______________________ Birthdate: __________ SS # __________

Sex ☐ M ☐ F Age: ______ Birthdate: __________ Spouse's Employer: ______________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ________ years

Whom may we thank for referring you? ______________________

DENTAL INSURANCE

Subscriber's Name: ______________________

Relationship to Patient: ______________________

Birthdate: __________ SS # __________

Insurance Co.: ______________________

Group #: __________ Phone: __________

Is patient covered by secondary insurance: ☐ Yes ☐ No

Subscriber's Name: ______________________

Relationship to Patient: ______________________

Birthdate: __________ SS # __________

Insurance Co.: ______________________

Group #: __________ Phone: __________

PHONE NUMBERS

Home: __________ Work: __________ Ext.: ______ Cell: __________

Spouse's Work: __________ Best time and place to reach you: __________

IN CASE OF EMERGENCY, CONTACT *(Specify someone who does not live in your household.)*

Name: ______________________ Relationship: __________

Home: __________ Work: __________ Ext.: ______ Cell: __________

DENTAL HISTORY

Reason for today's visit: ______________________

____

Former Dentist: ______________________

City/State: ______________________

Date of last dental visit: ______________________

Date of last dental X-rays: ______________________

How often do you floss? ______________________

How often do you brush? ______________________

Do you wear contact lenses? ☐ Yes ☐ No

Please check (✓) "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No

Reorder 2/13 OBS 1-800-634-1876

MEDICAL HISTORY

Physician's Name: ______________________________ Date of last visit: ______________

Phone: ______________ Pharmacy: ______________ Phone: ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? . . . . Yes No If yes, please explain: ______________

Have you ever been hospitalized or had a major operation?. Yes No If yes, please explain: ______________

Have you ever had a serious head or neck injury? . . . . Yes No If yes, please explain: ______________

Are you taking any medications, pills, or drugs? . . . . Yes No If yes, please explain: ______________

Do you take, or have you taken, Phen-Fen or Redux? . . . . . Yes No ______________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?. . . . . Yes No ______________

Are you on a special diet? . . . . Yes No

Do you use tobacco? . . . . Yes No

Do you use controlled substances?. Yes No

Are you allergic to any of the following? *(please circle)*

Aspirin Penicillin Codeine Local Anesthetics

Acrylic Metal Latex Sulfa Drugs

If yes, please explain: ______________

WOMEN: Are you pregnant/trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Alzheimer's Disease	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anaphylaxis	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Value	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spine Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Value Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Cortisone Medication	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above? Yes No

Comments: ______________

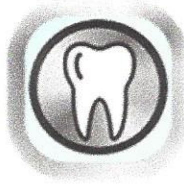
NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: ______________ Date: ______________

Updated ______________ Updated ______________

Updated ______________ Updated ______________



Vega Smile Studio

2499 GLADES ROAD, STE 208
BOCA RATON, FL 33431
(800) 392-6844

1. How did you hear about our office?

2. What is the reason for today's visit?

3. If you could change anything about your smile, what would it be?

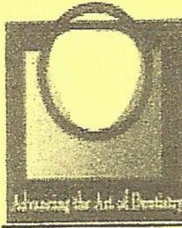
4. I have read/understand HIPPA regulations.

   Name: ________________________________

   Signature: ____________________________

   Date: _________________________________

Thank you for your cooperation.
Someone will be with you shortly.



Insurance and Financial Policy

We believe that you deserve the best care. That's why we always present you the best dental solution possible to treat. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefit, congratulations! **Here are some important things you should know...**

Your dental benefits are based upon a contract made between your employer and your insurance company.

We currently accept all private insurance plans. This means that we work with literally thousands of companies; therefore it is impossible to give you guaranteed quote at time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know exact insurance benefit, we will be happy to file a "pretreatment authorization" with your insurance company prior to treatment.

We bill your insurance as a **courtesy**, if the insurance does not pay within 90 days, **Vega Smile Studio** reserves the right to request payment in full for the services from you and let you collect the insurance funds that are due to you. This is rare but it is important you have is a legal contract between you and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. If your insurance company does pay us subsequent to your appeal, Vega Smile Studio will reimburse any credit on your account.

Vega Smile Studio does require payment in full for your portion at time of service. We accept Visa, MasterCard, Discover, cash and checks. If you are in need of an extended financial option, we also work with Care Credit, who offers twelve months "same as cash" or longer terms with an interest bearing revolving chare designed to meet your treatment plan needs on approved credit. Just ask of the patient services staff for an application.

BROKEN APPOINTMENT: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hour notice to avoid a $50.00/hour cancellation fee (emergencies are an exception).

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visit here more pleasant, please don't hesitate to ask one of our staff members.

Print: ______________________________

Sign: ______________________________

Date: ______________________________