Robin Dale Lobato, DDS, PC
COSMETIC & GENERAL DENTISTRY
www.drlobato.com

PATIENT INFORMATION

Patient First, Last Name:_____ Date :_____

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Child ☐ If a child, parent name(s):_____

Patient Nickname: _____ If married, spouse's name : _____

Patient address:_____ City:_____ State:_____ Zip:_____

Sex M ☐ F ☐ Home phone:_____ Work phone:_____

Cell phone:_____ Best number to confirm:_____

Email address:_____ Employer:_____ Occupation:_____

Is patient currently a full-time college student? Yes☐ No ☐ If yes, name & location of school:_____

Whom may we thank for referring you to our office?:_____

Person responsible for payment: Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Child ☐

Name:_____ Relationship to patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Birth date:_____ SS #:_____ Driver's license #:_____

Home phone:_____ Work phone:_____

Employer:_____ Employer address:_____

Insurance Information

NAME OF INSURED:_____ BIRTH DATE:_____ ID #:_____

NAME OF INSURANCE COMPANY:_____

POLICY #:_____ INSURANCE PHONE #:_____

Have any dental claims for this patient been filed with this insurance company this year prior to coming to our office today?

Yes☐ No ☐

Responsible Party & Financial Consent:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I understand I may be contacted on my cellular device or by email for financial purposes.
3. I understand that occasionally treatment quoted as necessary for the patient's dental health can change during the treatment process, and additional treatment may change in comparison to what has been financially estimated to me, and that insurance may not pay as quoted.
4. I understand and agree to be financially responsible for payment of dental services provided by this office due and payable at the time services are rendered. I understand additional fees apply for credit-card processing or collection accounts.
5. I authorize payment of services rendered by my insurance directly to Robin D. Lobato, DDS, PC. I understand that regardless of any insurance, I am responsible for payment of all services rendered. I agree that any balance over 60 days is subject to late fees and collection charges.
6. In the event that a check is returned to this office unpaid, I agree to have a $25.00 charge added to my account. I understand that a minimum charge of $58–$150.00 will be made for any failed or canceled appointment without 48 business hours' notice.

Patient signature: _____ Patient SSN#: _____

Responsible party signature:_____ Date:_____ Relationship to patient:_____

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MEDICAL HISTORY/CONSENT

Patient's name:_____ Date of birth:_____

MEDICAL HISTORY (Confidential) Your health history is vitally important in modern dental care. Please be complete:

Physician's Name:_____ Phone #:_____

When was your last complete physical exam?_____

Are you presently under a physician's care? Yes ☐ No ☐ If yes, explain:_____

Have you ever had a serious illness or operation? Yes ☐ No ☐ If yes, explain:_____

Have you taken in the past year and/or are you now taking any medication(s), drug(s), or pill(s)? Yes ☐ No ☐

If yes, list:_____

Do you have an allergy (hives, itching, redness, swelling) to any medication or substance? Yes ☐ No ☐

Penicillin☐ Sulfa ☐ Local Anesthetic ☐ Codeine ☐ Metals (gold, stainless steel) ☐ Latex ☐Aspirin ☐Fluoride ☐Other: _____

Please describe any current medical treatment, impending surgery, or other condition that may possibly affect your dental treatment:

_____

CHECK IF PATIENT HAS, OR HAS EVER HAD, THE FOLLOWING:

	Yes	No
High or Low Blood Pressure ☐ High ☐ Low	☐	☐
Heart Disease or Attack	☐	☐
Heart Pacemaker	☐	☐
Angina Pectoris	☐	☐
Heart Murmurs or Congenital Heart Lesions	☐	☐
Artificial Heart Valve Implant	☐	☐
Rheumatic Fever or Scarlet Fever	☐	☐
Artificial Joints/Prosthesis	☐	☐
Mitral Valve Prolapse	☐	☐
AIDs or Tested HIV Positive	☐	☐
Asthma or Other Lung Disorder	☐	☐
Blood Disorders (e.g., anemia, leukemia, etc.)	☐	☐
Blood Transfusion	☐	☐
Diabetes Diet Controlled ☐ Insulin Dependent ☐	☐	☐
Drug or Alcohol Dependency	☐	☐
Cosmetic Surgery	☐	☐
Epilepsy or Seizure Disorder	☐	☐
Fainting or Dizzy Spells	☐	☐
Glaucoma	☐	☐
Do you use tobacco products?	☐	☐
Hepatitis (Type:_____)	☐	☐

	Yes	No
Herpes (Cold Sores or Fever Blisters)	☐	☐
Inflammatory Diseases as Arthritis or Rheumatism	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Nervousness	☐	☐
Polio	☐	☐
Prolonged Bleeding	☐	☐
Prolonged Cough	☐	☐
Psychiatric Treatment	☐	☐
Radiation Treatment or Chemotherapy	☐	☐
Sickle-Cell Anemia	☐	☐
Sinus Infections	☐	☐
Stroke	☐	☐
Stomach Problems or Ulcers	☐	☐
Thyroid Problems	☐	☐
Tuberculosis	☐	☐
Venereal Disease	☐	☐
IF FEMALE: Pregnant or suspect that you may be?	☐	☐
Nursing	☐	☐
Taking hormones for birth control?	☐	☐

I have answered all of the questions to the best of my knowledge.

Consent:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
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DENTAL INTERVIEW

Patient's name:_____ Goes by:_____

Name of previous dentist:_____ How long:_____

Date of last dental exam:_____ For:_____ Date of last dental x-ray(s):_____

How often have you previously had your teeth cleaned? 3 mo_____ 4 mo_____6 mo_____ 1 yr or longer_____

CHECK IF PATIENT HAS, OR HAS EVER HAD, THE FOLLOWING :

Date of Interview:_____

	Yes	No
1. Orthodontic treatment	☐	☐
2. Wisdom teeth (3rd molars) removed	☐	☐
3. Any other teeth removed?	☐	☐
How? Fixed bridge___ Partial denture___Full denture__		
Any concerns about the replacement(s)?	☐	☐
Are you interested in replacement(s)?	☐	☐
4. Jaw get"stuck," "locked," or "go out"	☐	☐
5. Difficulty or pain when opening your mouth widely	☐	☐
8. Bite feels uncomfortable or unusual	☐	☐
7. Clenching or grinding your teeth	☐	☐
8. Jaw noises such as clicking or popping	☐	☐
9. Pain or soreness near the ears, temples, or cheeks	☐	☐
10. Frequent headaches or stiff neck muscles	☐	☐
11. Recent injury to your head, neck, or jaws	☐	☐
12. Previously been treated for a jaw joint problem	☐	☐

	Yes	No
13. Food traps that bother you	☐	☐
14. Teeth sensitive to: Hot___Cold___Sweets___Pressure___	☐	☐
15. Loose, cracked, or broken fillings	☐	☐
16. Cracked, broken, or sharp edges on any teeth	☐	☐
17. Discolored or stained teeth you would like whitened	☐	☐
18. Bleeding or aching gums	☐	☐
19. Avoid brushing any part of your mouth	☐	☐
20. Loose, tipped, or shifted teeth	☐	☐
21. An unpleasant taste or odor in your mouth	☐	☐
22. Previous gum treatment or gum surgery	☐	☐
23. Burning sensation in your mouth	☐	☐
24. Difficulty swallowing	☐	☐
25. Problems with dental anesthetic not working	☐	☐
26. Bad reaction to dental anesthetic	☐	☐
27. Preference for no dental anesthetic	☐	☐

28. Any problems or complications with any previous dental treatment? Yes ☐ No ☐
If yes, explain:_____

29. Is there anything we can do to help make your visits with us more comfortable? Yes ☐ No ☐
If yes, explain:_____

30. Have you ever been advised by a dentist to have treatment done that you have chosen NOT TO DO?_____

What is your immediate dental concern?_____

If you could wave a magic wand, how would you change your smile/teeth?_____

How do you feel about your past dental treatment?_____

Why did you decide to change dentists?_____

Tell me about your home care of your teeth?_____

How would you describe the general condition of your mouth?_____

OFFICE USE ONLY

Notes:_____

Phone: 702.877.0500 Fax: 702.877.9291 Email: info@drlobato.com 9061 W Sahara Ave, Ste 101 Las Vegas, NV 89117

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT:

Name:_____ DOB:_____

Best Contact #:_____ SS#:_____

Email address for digital contact:_____

PURPOSE OF CONSENT:

By signing this form, I will consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

I give Dr. Lobato and and staff the right to discuss my treatment with other healthcare professionals for the purpose of my desired result in treatment, or for the purpose of digital marketing of promotions. I am hereby also giving my consent to use any pictures in the same regard, and further consent to digital correspondence.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.75 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request a different format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide.

I understand that I have the right to read Dr. Lobato's full Notice of Privacy Practices before I decide whether to sign this Consent.

SIGNATURE:

I,_____, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information as noted under the purpose of consent.

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FINANCIAL AND SCHEDULING POLICY

Thank you for choosing our office for your dental care. We are committed to the success of your treatment. The following is a statement of our financial policy that we ask you to read and sign prior to any treatment. **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**. We accept cash, checks, Visa, Mastercard, Discover, and American Express. Any credit card transaction will be subject to credit card checkout fees at the office's current bank rate. For Care Credit, we offer payment plans up to 6 months same as cash only through outside lending companies' prior credit approval. Debit payments will not be charged a fee. Check payments are subject to bank fees should there be nonsufficient funds.

I have read the policy with regard to checkout fees that will be incurred with credit card payments, Care Credit financing, and check payments. **Initials:**_____ **Date:**_____

INSURED PATIENTS **Initials:**_____

As a courtesy we will bill and accept assignment of your insurance benefits. We will gladly offer estimates of your copays and process your claims for you. However, ALL COPAYS AND DEDUCTIBLES ARE DUE IN FULL AT THE TIME OF SERVICE. Should your insurance carrier deny part of your entire claim, then it is your financial responsibility. Your insurance policy is a contract between you and your insurance carrier. We are not a party to the contract. After 60 days, we will continue to assist you in collecting from your insurance company. However, administrative fees of $15 per correspondence may apply. If your insurance does not pay your claim within 60 days, you will be responsible for payment. Regarding insurance plans where we are a participating provider, ALL COPAYS AND DEDUCTIBLES ARE DUE IN FULL AT THE TIME OF SERVICE. We will accept the "allowed amount" as it is stipulated in our contract with the insurance company. However, if a service is not covered or your insurance allows an alternate code, then the difference is your financial responsibility.

MISSED OR CANCELED APPOINTMENTS **Initials:**_____

Please help us serve you and our other patients better by keeping scheduled appointments. We do not stack or double-book patients. Therefore, appointments that are missed or canceled without 48 hours' notice will be charged an hourly office-visit fee. This fee may be a 10% nonrefundable fee of the actual appointment planned. We may require 50% of your estimated portion at the time of scheduling. If you must cancel or reschedule an appointment, we require 48 business hours' (M-Th) notice and 7 days' notice for any appointment time scheduled for over 1 ½ hours. Fees will apply to repeat cancellations beginning on the second failure to provide notice as indicated above. PLEASE CONSIDER YOUR SCHEDULE CAREFULLY WHEN MAKING APPOINTMENTS.

NOTE: ALL PAYMENTS ARE DUE PRIOR TO BEING SEEN **Initials:**_____

Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions.

I have read the Financial and Scheduling Policy; I understand and agree to this Financial and Scheduling Policy.

Name of Patient(s):_____

_____ _____

Signature of Patient or Responsible Party Date

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CONSENT FOR DISCLOSURE CONTACT AND RELEASE OF RECORDS

I authorize you to release or receive my records to/from:_____

And/or _____ (initial) send any referral or specialist information and records I receive from our office

And (other)_____ (initial)_____

Patient Name (print):_____

I agree and consent to allow Robin D. Lobato, DDS, PC, and/or employees of Robin D. Lobato, DDS, PC, to contact me directly in any fashion I list below:

May leave personal health information message:

Home Phone:_____ (initial)_____

Cellular Phone:_____ (initial)_____

Work Phone:_____ (initial)_____

Other Phone:_____ (initial)_____

Email Address:_____ (initial)_____

I authorize Robin D. Lobato, DDS, PC, and/or employees of Robin D. Lobato, DDS, PC, to discuss any treatment or health concerns with:

Name:_____

Phone:_____ Relationship:_____

Name:_____

Phone:_____ Relationship:_____

Patient or Guardian

Signature:_____ Date:_____

Witness:_____ Date:_____