



Shalom Sunset Dental

## WELCOME.

We offer you a warm welcome to our office, all our doctors and workers will attend you with respect and dedication that you deserve.

It is our main objective to make you feel in trust and confidence with the services we offer you.

We are a clinic dedicated to the care, cleaning and oral health of our patients, providing them with comprehensive care, using cutting-edge technology to your satisfaction and with prices available to our community.

To achieve our goals and ensure that all are treated with the same level of respect, each patient will have:

The responsibility of:

- In the event of unforeseen or emergency, we ask you please call at least 24 hours before your appointment, to cancel or get another.
- Behave quietly and orderly, notifying staff any dissatisfaction or concern with respect to the treatment and received treatment.
- Respect and care for our property as well as office buildings.
- Comply with its obligations of payment immediately prior to their appointment or before receiving their work.
- Pay in full or without discounts, if they had it, when you modify the initial treatment signed and proposed by our doctors.

The right a:

- Be treated with dignity, consideration and respect, offering privacy and appropriate confidentiality.
- Offer you the opportunity to approve or reject their treatment options with explanations appropriate diagnosis, treatment and prognosis.
- Receive a safe and efficient treatment.

By signing below you confirms that he has understood the Protocol of our office and is willing to comply with it.

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**Patient Name**

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**Date**

# WELCOME TO OUR PRACTICE!



Shalom Sunset Dental Care  
Dr. Blanca M. Castello

6491 Sunset Strip Suite #1  
Sunrise FL, 33313  
Phone: (954) 572-1801

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

## PATIENT INFORMATION

Date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail \_\_\_\_\_  
Sex:  M  F  Minor  Single  Married  Long Term Partner  Divorced  Widowed  Separated  
Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Who should we thank for referring you? \_\_\_\_\_  
In case of emergency, who should we contact? \_\_\_\_\_ Phone \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Responsible Party Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

## ADDITIONAL INSURANCE

Insured Name \_\_\_\_\_  
Last Name First Name Initial  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insured Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_



## DENTAL HISTORY

Former Dentist \_\_\_\_\_

Date of Last X-Rays \_\_\_\_\_

City, State \_\_\_\_\_

How Often Do You Floss? \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_

How Often Do You Brush? \_\_\_\_\_

Please check all that apply:

Bad Breath.....   
 Bleeding Gums .....   
 Blisters on Lips or Mouth .....   
 Finger Nail Biting .....   
 Grinding Teeth .....   
 Lip or Cheek Biting .....

Loose Teeth or Broken Fillings.....   
 Orthodontic Treatment .....   
 Pain Around Ear .....   
 Periodontal Treatment .....   
 Sensitivity to Cold .....   
 Sensitivity to Heat .....

Sensitivity to Sweets .....   
 Sensitivity When Biting .....   
 Frequent Headaches .....   
 Jaw, Head or Neck Injuries .....   
 Jaw Difficulty: Clicking and/or Pain..   
 Tooth Pain .....

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

1. Are you currently under medical treatment? .....  Yes  No  
 2. Have you ever had any serious illnesses or operations? .....  Yes  No  
 3. Are you currently taking any medication? .....  Yes  No

Please describe: \_\_\_\_\_

4. Do you smoke? .....  Yes  No  
 5. Do you use alcohol, cocaine or other drugs? .....  Yes  No  
 6. Do you wear contact lenses? .....  Yes  No

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine) .....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other Antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates (sleeping pills) .....	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives .....	<input type="checkbox"/>	<input type="checkbox"/>
Iodine .....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>
Other .....	<input type="checkbox"/>	<input type="checkbox"/>

8. (Women Only) Are You:

	Yes	No
Pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>
Nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills? .....	<input type="checkbox"/>	<input type="checkbox"/>

Please check all that apply:

AIDS .....   
 Anemia.....   
 Arthritis, Rheumatism .....   
 Artificial Heart Valves .....   
 Artificial Joints .....   
 Asthma .....   
 Back Problems .....   
 Bleeding abnormally, with extractions or surgery .....   
 Blood Disease .....   
 Cancer .....   
 Chemical Dependency .....   
 Chemotherapy .....   
 Chronic Fatigue Syndrome .....   
 Circulatory Problems .....   
 Congenital Heart Lesions.....   
 Cortisone Treatments .....   
 Cough - persistent or bloody.....   
 Diabetes.....

Emphysema .....   
 Epilepsy .....   
 Fainting or Dizziness .....   
 Glaucoma .....   
 Headaches.....   
 Heart Murmur .....   
 Heart Problems.....   
 Hepatitis-Type .....   
 Herpes.....   
 High Blood Pressure .....   
 HIV Positive .....   
 Jaundice .....   
 Jaw Pain .....   
 Latex Sensitivity .....   
 Kidney Disease .....   
 Liver Disease.....   
 Low Blood Pressure .....   
 Mitral Valve Prolapse.....   
 Nervous Problems.....

Pacemaker.....   
 Psychiatric Care .....   
 Radiation Treatment.....   
 Respiratory Disease.....   
 Rheumatic Fever .....   
 Scarlet Fever .....   
 Shortness of Breath .....   
 Sinus Trouble.....   
 Skin Rash .....   
 Stroke .....   
 Swelling of Feet/Ankles.....   
 Swollen Neck Glands.....   
 Thyroid Problems.....   
 Tonsillitis .....   
 Tuberculosis.....   
 Tumor or growth on head/neck.....   
 Ulcer.....   
 Venereal Disease .....

## ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. Blanca M. Castello for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

***Shalom Sunset Dental Care***  
***Dr. Blanca M Castello***  
**General Dentistry Informed Consent**

Patient Name (Please Print): \_\_\_\_\_

1. **Work To be Done:** I understand that I am having the following work done: \_\_\_:Fillings; \_\_\_:Bridges; \_\_\_:Crowns; \_\_\_:Extractions; \_\_\_:Impacted teeth removal; \_\_\_:I.V. Sedation; \_\_\_:Root Canals; \_\_\_:Other. Initials: \_\_\_\_\_
2. **Drugs and Medications:** I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. Initials: \_\_\_\_\_
3. **Changes in Treatment Plan:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary to guarantee the best results. Initials: \_\_\_\_\_
4. **Removal of Teeth:** alternatives to removal of teeth they have explained to me (Root Canal Therapy, Crown, and/or Periodontal surgery, ect.) and I authorize the dentist to remove the teeth and any other necessary for reason in paragraph three. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even a hospital if complications arise during or following treatment, the cost of which is responsibility. Initials: \_\_\_\_\_
5. **Leukocyte-Platelet Rich Fibrin (L-PRF):** PRF rejuvenation is used to promote healing and bone growth from within your body. If the patient has health problems then the doctor will not be able to draw blood or the blood drawn will not be optimal for the procedure. Results may vary from patient to patient. Initials: \_\_\_\_\_
6. **Crowns, Bridges, and/or Caps:** I understand that sometimes it is not possible to match the natural color of my teeth exactly with artificial teeth. I further understand that I may be wearing a temporary crown, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, and/or veneer will be before cementation. If any changes need to be made after cementation, an additional fee will be charged to the patient. Initials: \_\_\_\_\_
7. **Dentures- Complete or Partials:** I realize that full or partial dentures are artificial constructed of plastic, metal and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize that the final opportunity to make any changes in my new dentures (shape/fit/size/placement/color) will be at the "teeth try-in" visit. I understand that any changes after the dentures are completely may require an additional fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial dentures fee. Initials: \_\_\_\_\_
8. **Endodontic Treatment (Root Canal):** I realize that there is no guarantee that the root canal therapy will save my tooth, that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root tip which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). Initials: \_\_\_\_\_
9. **Periodontal Loss (Tissue & Bone):** I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. Initials: \_\_\_\_\_

I understand that dentistry is not an exact science and therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which 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 understand that no other dentist other than the treating dentist is responsible for my treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# *Shalom Sunset Dental Care*

*Dr. Blanca M Castello*

## **Written Financial Policy:**

Thank you for choosing Shalom Sunset Dental Care. Our mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients by offering several payment options.

### **Payment Options:**

- ❖ Cash, Visa, Mastercard, American Express, and/or Discovery.
- ❖ Convenient monthly payment options from CareCredit Healthcare Credit Card.
  - Allows our patients to pay over a period of time.
  - No annual fees or prepayment penalties.

**Please Note:** Shalom Sunset Dental Care requires payment prior to the completion of your treatment. If you choose to discontinue care before the treatment is complete, you will receive a refund minus the care received and any penalties if applicable.

We accept payments in Thirds or Fourths for treatments over \$1000. For plans requiring more than 3 appointments, alternative arrangements may be provided for larger, more comprehensive treatment plans of \$1000 or more, a deposit is required to secure your initial treatment appointment. We also offer in house financing for treatments over \$2000.

For patient with dental insurance, we are more than happy to work with your carrier to maximize your benefits and directly bill them for any reimbursement for your treatment.

**Please Note:** The patient is responsible for any difference between the treatment estimate and what the carrier pays.

A fee of \$20 will be charged to patients who miss or cancel more than 2 appointments in a calendar year without a 48 hour notice or a \$50 for any appointments that are for procedures.

Shalom Sunset Dental Care will charge the patient an additional \$30 for any bounced checks.

If the patient's account has to be sent to collection the patient agrees to be responsible for any fees from the collection agency, legal fees, and/or additional penalties from the office.

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Patient/Parent/Guardian Signature

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Date

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Patient Name (Please Print)

*Shalom Sunset Dental Care*

*Dr. Blanca M Castello*

**6491 Sunset Strip Suite #1**

**Sunrise, FL 33313**

**Notice of Privacy Practices Acknowledgement**

I understand the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❖ Conduct plan, direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ❖ Obtain payments from third-party payers.
- ❖ Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my request restricting the use of my information, but if you do agree then you are bound to abide by such restrictions.

If anyone will be contacting us to ask about your treatment or to discuss your treatment estimate, please list their name and relationship to you. Otherwise we will be unable to speak with them or discuss any information regarding your case.

Patient Name: \_\_\_\_\_

Relatives Name/Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Official Use Only**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unsuccessful as document below:

Date: \_\_\_\_\_ Initial: \_\_\_\_\_ Signature: \_\_\_\_\_

Reason: \_\_\_\_\_