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.

______________________________ __________________

Patient Name **Date**

BRUSH SMILES FLOSS DENTIST HEALT
DENTIST HEALTHY GUMS HYGIENIS

WELCOME

We are pleased to welcome you and 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 your child.

PATIENT INFORMATION

Child's Name ______________________ Soc. Sec. # ______________
Last Name *First Name* *Initial*

Address ______________________

City ______________ State ________ Zip ________ Home Phone ______________

Cell Phone ______________ Email ______________

Sex ❑ M ❑ F Age ______________ Birthdate ________ School ______________

Grade ______________ Hobbies/Sports ______________

Whom may we thank for referring you? ______________________

Notify in case of emergency ______________________ Home Phone ______________

Business Phone ______________ Cell Phone ______________ Email ______________

PRIMARY INSURANCE

Person Responsible for Account ______________________
Last Name *First Name* *Initial*

Relation to Child ______________ Birthdate ______________ Soc. Sec. # ______________

Address *(if different from child)* ______________________

City ______________ State ________ Zip ________ Home Phone ______________

Cell Phone ______________ Email ______________

Person Responsible Employed by ______________________ Occupation ______________

Business Address ______________________ Business Phone ______________

Business Email ______________ Insurance Email ______________

Insurance Company ______________________ Phone ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Name of other dependents under this plan ______________________

ADDITIONAL INSURANCE

Is child covered by additional insurance? ❑ Yes ❑ No

Subscriber Name ______________ Relation to Child ______________ Birthdate ______________

Address *(if different from child)* ______________________ Soc. Sec. # ______________

City ______________ State ________ Zip ________ Home Phone ______________

Cell Phone ______________ Email ______________

Subscriber Employed by ______________________ Business Phone ______________

Business Email ______________ Insurance Email ______________

Insurance Company ______________________ Phone ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Name of other dependents under this plan ______________________

Please complete both sides.

DENTIST HEALTHY GUMS HYGIENIST TEETH OPEN
OOTHPASTE BRUSH SMILES FLOSS
NTIST HEALTHY GUMS HYGIENIST

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 ____________________

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

Please describe: ____________________

____

4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

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

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

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 math 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 realise 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 lossenes, 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 in not an exact science and therefore reputable practitioners cannot properly cannot 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.

________________________________ ____________

Patient/Parent/Guardian Signature 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 od 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: ____

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:____