Dr. Victor Matute, D.D.S.

New Patient Registration

CONSENT FOR SERVICES

Our goal is to provide dental services to you in the most beneficial manner possible. This requires our mutual understanding. Please read the following information carefully and ask questions about anything you do not understand. We will answer all your questions and concerns.

1. I hereby authorize and direct Dr. Victor Matute, assisted by other dentists and/or dental assistants of his choice, to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2. I understand certain parts of the treatment may be performed by certified paraprofessionals (dental assistants) other than the dentist.

3. **I understand that during treatment it may be necessary to change or add procedures because conditions were found while working that were not visible during examination, the most common being root canal therapy following restorative procedures. Any changes made will result in a change in fees originally discussed. I hereby give my permission for Dr. Matute to make any/all changes and additions as necessary.**

4. I understand x-rays, photographs, models of the mouth, and/or any other diagnostic aids used for an accurate diagnosis and treatment plan are the property of the doctor but copies are available upon request.

5. In general terms, the dental procedure(s) can include but are not limited to:
   - Comprehensive oral examination, radiographs, and cleaning of the teeth
   - Treatment of diseased or injured teeth with dental restorations (fillings), composites, crowns, bridges, extractions, and/or root canal treatment.
   - Treatment of diseased or injured oral tissues secondary to traumatic injuries, and/or accidents, and/or infection
   - Construction of full or partial plastic, metal, and/or porcelain dentures
   - Use of anesthesia agents and/or antibiotics and analgesics

6. I understand that the doctor is not responsible for previous dental treatment. I understand that in the course of treatment this previously existing dentistry may need adjustment and/or replacement.

7. I realize that guarantees of results or absolute satisfaction are not possible in dental health services.

8. I have answered all the questions about my medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all conditions, including allergies that might indicate that I should not receive oral l medications and/or anti-anxiety agents. I also understand that if I ever have any changes in health status or any changes in medication(s). I will inform the doctor at the next appointment.

9. I authorize Dr. Victor Matute to forward a review of finding and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care provider for his/her records, as well as any third parties such as insurance companies that may request information.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

_____ _____ Dr. *Victor Matute*

Patient's Signature Date

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PATIENT INFORMATION

Patient's Name:_____ **Date:**_____

Address:_____ **Apt. #**_____

City:_____ **State:**_____ **Zip:**_____

Gender: □ Male □ Female **Family Status:**□ Single □ Married □ Divorced □ Widowed □ Other_____

Social Security #:_____ **Birth Date:**_____

HIPPA: Do we have permission to leave appointment, billing or dental information on your answering machine, voicemail or e-mail at the following numbers? Please check "Yes" or "No" for each contact number.

Phone Numbers: Home:_____ □ Yes □ No

Work:_____ □ Yes □ No

Pager:_____ □ Yes □ No

Cell:_____ □ Yes □ No

In case of an emergency, contact:_____ Phone:_____

HIPPA: The patient and the guarantor who are signatories hereto hereby give permission to the office of Dr. Victor Matute to discuss and share appointment, treatment, billing and/or other dental information with the following persons:_____ _____ (if left blank, all family members and other persons residing in the patients home are approved)

RESPONSIBLE PARTY/GUARANTOR INFORMATION

The person responsible for this account is □ the patient or □ the following person:

Name:_____ **Relationship to Patient:**_____

Address:_____ **Apt. #**_____

City:_____ **State:**_____ **Zip:**_____

Gender: □ Male □ Female **Family Status:**□ Single □ Married □ Divorced □ Widowed □ Other_____

Social Security #:_____ **Birth Date:**_____

Phone Numbers: Home:_____ Work:_____ Cell:_____

REFERRAL INFORMATION

How did you learn about, or who referred you to, our dental office? □Patient/Friend_____
□Yellow Pages □Our Staff_____ □Radio □Other_____

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INSURANCE INFORMATION

Primary Insurance

Name of Primary Subscriber/Insured:_____ Is this insured a patient? □Yes □No

Relationship to Patient: □Self □Spouse □Child □Other_____

Insured's Social Security #:_____ Birth Date:_____

Insured's Address:_____

Insured's Employer_____ Group #:_____

Insurance Company:_____ Member ID#:_____ __

Insurance Company Address:_____
_____ 800#_____

PATIENT'S HEALTH INFORMATION

Have you ever had any of the following health problems, conditions, or habits? Please check those that apply:

□ AIDS
□ Allergy (Codeine)
□ Allergy (Penicillin)
□ Allergy_____
□ Anemia
□ Arthritis, Rheumatism
□ Artificial Hearth Valves
□ Artificial Joints, Pins…
□ Asthma
□ Back Problems
□ Bleeding Abnormally
□ Blood Disease
□ Cancer
□ Chemical Dependency
□ Chemotherapy
□ Circulatory Problems
□ Congenital Heart Defect
□ Cortisone Treatments
□ Cough, Persistent
□ Cough up blood
□ Diabetes
□ Dizziness
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Growths
□ Hay Fever
□ Headaches
□ Head Injuries
□ Heart Disease
□ Heart Murmur
□ Hemophilia
□ Hepatitis
□ Hernia Repair
□ High Blood Pressure
□ Jaundice
□ Jaw Pain
□ Kidney Disease
□ Liver Disease
□ Mental Disorders
□ Mitral Valve Prolapse
□ Nervous Disorders
□ Pacemaker
□ Pregnancy
Due Date_____
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Rheumatism
□ Scarlet Fever
□ STD
□ Shortness of Breath
□ Sinus Problems
□ Skin Rash
□ Smoking #__/year__
□ Stomach Problems
□ Stroke
□ Swelling of Feet/Ankles
□ Substance Abuse
□ Thyroid Problems
□ Tobacco Habit
□ Tonsillitis
□ Tuberculosis
□ Tumors
□ Ulcers
□ Other:_____
_____
□ Low Blood Pressure

Have you ever had any of the following dental problems or conditions? Please check those that apply:

□ Bad Breath
□ Bad Taste
□ Bleeding Gums
□ Clicking/Popping of Jaw
□ Food caught between teeth
□ Grinding or clenching teeth
□ Loose Teeth
□ Broken Fillings
□ Periodontal Treatment
□ Sensitivity to cold
□ Sensitivity to sweets
□ Sensitivity to hot
□ Sensitivity when biting
□ Sores in the mouth
□ Local Anesthetic (Novocain)
□ Nitrous Oxide
□ Prolonged bleeding
□ General Anesthetic
□ Extractions
□ Braces

Please answer the following dental/medical questions:

- Have you ever been, or do you need to be premedicated for dental work? □ Yes □ No
- How often do you floss? _____
- How often do you brush? _____
- Have you ever worn dentures or partials? □ Yes □ No If so, how old are they? _____
- Have you ever had any complications following dental treatment? □ Yes □ No

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If so, please explain: _____

- Have you been admitted to a hospital or needed emergency care in the past two years? □ Yes □ No
  If so, please explain: _____
- Are you pregnant? □ Yes □ No Are you nursing? □ Yes □ No
- Are you taking birth control pills? □ Yes □ No
- Are you now under the care of a physician? □ Yes □ No
  If so, please explain:_____
- Name of Physician:_____Phone:_____
- Do you have any health problems that need further clarification? □ Yes □ No
  If so, please explain:_____
- Please list all medications currently being taken and the related diagnosis or medical condition:_____

_____

_____

TERMS AND CONDITIONS OF SERVICE

In consideration of all services provided by Dr. Victor Matute and his employees, contractors and/or affiliates, the undersigned hereby acknowledges and agrees (on behalf of himself or herself and his or her children, dependents and other persons for whom he or she serves as guarantor) with the following terms and conditions of service:

Medical Information: The undersigned hereby certifies that all information provided to Dr. Victor Matute is true, correct and complete and agrees to promptly inform Dr. Matute of any changes in any information (including regarding any Dependent). Dr. Matute is authorized to use and disclose to any insurance, billing, management or processing company, agency or organization any health care information/medical records relating to the undersigned or any dependent to obtain payment for services, determined insurance benefits or otherwise as required by law. Dr. Matute is authorized to contact the undersigned at any telephone number provided (unless otherwise revoked in writing) to discuss this forma and any billing, treatment, or other matter related to any dental treatment (including for any dependent).

Transferring of Records: If you need your records to be transferred, you must make your request in writing. If you want to have a copy of your records sent to another doctor or organization, there will be a fee of $35.00 for x-rays and $1.00 per file page.

Treatment; Informed Consent: The undersigned authorizes Dr. Matute and any treating dentist, hygienist and/or staff to perform all treatment described in any treatment plan (and including all other services determined by such dentist to be necessary or appropriate in connection with such treatment plan) accepted by undersigned for himself/herself or any Dependent. Dentistry is a biological procedure and not an exact science; therefore despite the highest standard of care, no guarantee is or can be given by Dr. Matute or any dentist or any other person employed or contracted by Dr. Matute regarding any treatment or the results that may be obtained. The patient must comply with all specified appointments, procedures and continuing care and failure to do so will adversely affect the patient's treatment often necessitating additional required treatment (or pretreatment) with additional fees. **Failure to provide notice for missed appointments will result in a fee as explained below.**

Financial Responsibility; Insurance: The undersigned assumes absolute responsibility for payment of all fees and charges for all services of Dr. Matute, whether or not covered by insurance. The patient's portion of all fees is due and payable in full at the time services are performed (for treatment involving multiple appointments, such as prosthetics, the entire patient portion is due prior to completion of treatment). Any special financial arrangements must be made before treatment is started. All insurance information must be presented before treatment is started. Dr. Matute submits insurance claims for patients' convenience and does not assume responsibility for the processing of such insurance or failure of insurance to pay for any reason. Dental insurance rarely covers all fees; estimated or preauthorized insurance benefits are not guaranteed. The undersigned agrees to promptly pay on demand any balance not paid by insurance within 60 days after the date of service. A service charge of 1 ½% per month (18% per annum) is charged on all balances more than 30 days past due. Insurance balances are considered past due if not paid within 60 days of the date of service. The undersigned shall pay all costs incurred by Dr. Matute relating to collection of any unpaid or delinquent balance (including, without limitation, attorneys and collection agency fees, court costs, paralegals) whether or not suit is filed. Dr. Matute reserves the right to terminate of deny any treatment if the patient's account becomes delinquent.

Assignment of Benefits; Authorization and Release: The undersigned hereby certifies that all insurance described above is current and valid and assigns directly to Dr. Matute all insurance benefits otherwise payable to the undersigned or any dependent for all services rendered. The undersigned hereby agrees that his/her signature below will be maintained on file; Dr. Matute is authorized to use such signature on all applicable insurance claims and submissions.

Notice of Privacy Practices: The undersigned has reviewed a copy of Dr. Matute's Notice of Privacy Practices.

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CANCELLATION/NO SHOW POLICY

Our office makes every effort to keep your care as affordable as possible. In order to help meet this goal, we have the following policy regarding cancellations and no shows. We ask that if you must cancel that you do at least 24 hours in advance during the week and 48 hours in advance for Saturday appointments. Not following pre-appointment instructions in regards to pre-medication, dietary restrictions, etc., also falls within this policy. Cancellations and no shows that do not abide by this policy will be subject to the following fees:

Weekday appointment cancellation/no show - $45.00
Saturday appointment cancellation/no show - $55.00
Before/After hours appointment cancellation/no show - $60.00

Please understand that we have instituted this policy in order to help serve our patients better and more affordably. We appreciate your cooperation.

INSURANCE COLLECTION POLICY

As a courtesy to our patients, we collect an estimated co pay at the time of service.
But, because your insurance company does not guarantee benefits until a claim is filed, the patient or parent is held in full responsibility of each claim submitted whether a claim is paid in full or partially.

If a claim is outstanding for more than 60 days, the patient or parent is held in full responsibility to pay the claim/balance in full and get reimbursement from the insurance company. Because the doctor's time is valuable, the doctor also must get paid for services rendered.

There is no guarantee that any insurance company will pay any claim. The treatment plans given are strictly an estimate and not a guarantee that the insurance company will pay the claim.

Please read the above carefully. Ask any questions if you do not understand what you are reading before signing this form.

I understand my insurance company may not pay my claims in full and I take full responsibility to pay any remaining balance.

I have read the above terms and conditions of services by Dr. Matute and understand and accept such terms.

Name of Patient	Signature of Resp. Party	Date