# Welcome

Dr. Florencio T. Burquez, D.D.S.
Otay Lakes Medical & Dental Center
2452 Fenton Street, Suite 102
Chula Vista, CA 91914

## Patient Information

Date _____ Home Phone (____) _____ Cell Phone (____) _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

## Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ ID#/Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

## Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

**Please Complete Both Sides**

# Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check ( ✓ ) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

ARE YOU HAPPY WITH THE APPERENCE OF YOUR SMILE? ○○

HAVE YOU HAD ANY ORTHODONTIC WORK? ○○

How often do you floss? _____ How often do you brush? _____

# Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

HAVE YOU TAKEN BONE SPARING DRUGS SUCH AS FOSAMAX, ACTONEL, BONIVA OR ZOMETA? Y ○ N ○

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check ( ✓ ) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

_____

# Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. FLORENCIO T. BURQUEZ D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

***Payment is due in full at time of treatment unless prior arrangements have been approved.***

Florencio T. Burquez D.D.S.
*Family & Cosmetic Dentistry*

Patient's Name _____ Date _____

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR DOCTOR BEFORE INITIALING.

_____1. **TREATMENT:**
I understand I am having the following dental treatment performed:
o Fillings o Crowns o Bridges o Dentures o Extractions
o Impacted tooth removal o Root Canals o Other

_____2. **Drugs and Medications:**
I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs. Female patients: Antibiotic medications can interfere with the effectiveness of oral contraceptives (birth control pills). You should maintain compliance with your oral contraceptives while taking the antibiotic but you should discuss with your physician the use of additional non-hormonal means of contraception to avoid possible unwanted pregnancy.

_____3. **Fillings:**
I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth restoration. I realize that fillings are rarely "permanent" and usually require periodic replacement.

_____4. **Crowns and Bridges:**
I voluntary consent to the crown or bridge which has been recommended to me. I have been informed that crowns that cover the tooth strengthen and help protect the tooth from fracture. I understand that a tooth can still break after being crowned. I also have been informed that bridges replace missing teeth. This is necessary in order to prevent or correct bite or gum problems which may occur when teeth shift position. Crowns and bridges are made of all porcelain or a combination of precious metals and porcelain.

Risks involved:
Preparation for the crown or bridge might reveal the need for a root canal procedure on the tooth.
After placement, the porcelain portion of the crown or bridge may crack and may require repair or replacement.
TMJ or temporomandibular joint dysfunction may occur if the crown or bridge changes the alignment of the teeth, which may require additional treatment.

I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will notify my doctor of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication of the restoration. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I understand I may need further treatment by a specialist if complications arise during treatment, and any costs thus incurred are my responsibility.

I understand that the areas around crowns and bridges are harder to keep clean. I have further been informed that it is necessary to keep the areas free of food and other substances which can lead to decay and periodontal disease. I have been given instructions to follow to keep these areas clean and agree to follow the instructions carefully. I have further agreed to be treated by the dental hygienist 2 –4 times a year.

_____5. **Dentures:** I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished, and that dentures are not "permanent." Sore spots, altered speech and difficulty eating are common problems. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate dentures require frequent adjustment and one or more permanent relines within several months. I understand that failure to keep appointments may result in a less desirable result. If remake is required due to my delay, additional fees may be incurred.

_____6. **Extractions:** Alternatives to tooth removal include root canal therapy, extensive restoration, periodontal (gum) treatment or crowns. It is my understanding that the following teeth will be removed:_____ _____. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I have been told that the risks of removing teeth include, but are not limited to: pain, swelling, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip and or other facial areas, cheek, tongue, gums and teeth. Such numbness may be temporary or permanent. I understand that further care by a specialist may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

_____7. **Periodontal Disease:** Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

_____8. **Root Canal Therapy:** I realize there is no guarantee that root canal treatment will save a tooth, and that complications can occur from treatment. Occasionally the canal filling material may extend through the end of the root, which may or may not effect the success of treatment, and which may require additional treatment. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not effect success. I understand that occasionally additional surgical procedures (apicoectomy) may be necessary to complete therapy. I also understand that an undetectable hairline crack in a tooth may cause failure, no matter how extensive therapy may be. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise.

_____9. **Changes in Treatment Plan:**
I understand that during treatment it may be necessary to change or add procedures because of conditions discovered during treatment that were not evident during examination. I authorize my doctor to use professional judgment to provide appropriate care.

_____10. **Alternative Treatment(s):**
Include: _____
_____
_____
_____
_____

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated laboratory fees are my financial responsibility.

CONSENT: I have had the opportunity to have all my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

_____
Patient's (or Legal Guardian's) Signature Date

_____
Doctor's Signature Date

_____
Witness' Signature Date

DR.FLORENCIO T. BURQUEZ D.D.S.
2452 FENTON ST STE.102
CHULA VISTA CA, 91914
(619)934-4216

**Insurance / Financial Policy**

Thank you for choosing Dr. Burquez as your dental care provider. We restive to provide the very best service to our patients in every way possible and highly committed to your treatment being successful. Please understand that payment of our bill is considered a part of your treatment. The following is our financial policy, which we require you to read an d sign prior to any treatment.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE**
We accept cash, Visa, MasterCard, Discover, American Express, Care Credit and personal check. **There will be a fee of $45.00 charged on all returned checks.**

**REGARDING INDEMNITY INSURANCE**
Dr. Burquez will process any insurance claims as a courtesy to our patients. However, we cannot guarantee that your insurance company will pay the "estimate" figure. The balance is your responsibility whether your insurance company pays or not. Therefore, the balance of the account remains always the sole responsibility of the patient. Your dental insurance policy is a contract between you and your insurance company. We are not a party within the contract. Please be aware that some and perhaps all of the services provided may be non-covered services under your dental policy. All co-pays and deductibles are due at the time of treatment.

**USUAL AND CUSTOMARY RATES**
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. All insurance companies are not the same in what they consider to be usual and customary fees. Please be advised that many times insurance companies pay for the least alternative treatment. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We recommend that you take the time to read over your policy and contact your carrier if you have any questions regarding your coverage.

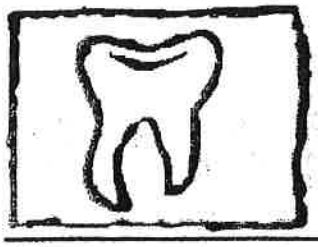
**MINOR PATIENTS**
The adult accompanying a minor and the parents/guardian of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment method at the time of service.

**INTEREST**
In order to allow us to provide the best quality care and maintain the lowest fees possible, there is a 1 ½ % financial charge ( 18% APR) on any unpaid balance carried for more than 60 days.

**BROKEN APPOINTMENTS**
There will be a $50.00 minimum charge for any broken appointment or appointment cancelled with less than a 24-hour notice.

**Thank you for understanding of our financial policy. Please let us know if you have any questions or concerns. By signing this, I acknowledge that I have read, understand and agree to the terms of this financial policy.**

Signature of Patient/Guardian:_____ Date:_____



**Florencio T. Burquez D.D.S.**

## Acknowledgement of Receipt of Notice of Privacy Practices

I herby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be with the receptionist at any time that I may need a copy of it.

Print name:_____ Date:_____

Signed:_____ Acc#:_____

If not signed by patient, please indicate:

Relationship:

- ❑ Parent or guardian of minor patient.
- ❑ Guardian or conservator of an incomplete patient
- ❑ Beneficiary or personal representative of deceased patient

Name:_____