



*Highland Dental Care*  
Compassionate Family Dentistry

**Patient Acquaintance Form**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: (M /F) Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status: \_\_\_\_

E-mail: \_\_\_\_\_

Insurance Coverage (Y/N)

Name of Insured \_\_\_\_\_

Date of Birth of Insured: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security of Insured: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Employer Name: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Medical History**

(Yes/No) Are you allergic to any drugs or medications? If yes, please list \_\_\_\_\_

(Yes/No) Do you have artificial joints such as knee or hip replacements?  
if yes date of surgery \_\_\_\_\_, doctor who performed surgery. \_\_\_\_\_

(Yes/No) Have you been told you need to premedicate with an antibiotic prior to your Dental appointment

(Yes/No) High blood pressure? If yes, please list medication: \_\_\_\_\_

(Yes/No) A heart ailment, including mitral valve prolapse or heart murmur? \_\_\_\_\_

(Yes/No) Do you have a history of heart surgery? If yes, please list: \_\_\_\_\_

(Yes/No) Do you have Diabetes?

(Yes/No) Do you have Rheumatic fever?

(Yes/No) Do you have HIV or AIDS? If yes, please list medication: (Yes/No) (Yes/No)

\_\_\_\_\_

(Yes/No) Do you have Hepatitis? If yes, please list type: \_\_\_\_\_

(Yes/No) Have you ever had any radiation treatment?

(Yes/No) Do you have epilepsy, convulsions, or seizures?



*Highland Dental Care*  
Compassionate Family Dentistry

(Yes/No) Do you have any pain in or near your ears?

(Yes/No) Are you pregnant? If yes, how many months? \_\_\_\_\_

Are there any other conditions we should be aware of? \_\_\_\_\_

Are you presently taking drugs or medications not listed above for any other medical condition? If yes, please list: \_\_\_\_\_

**Dental History**

**Do you have or have you ever had any of the following:** Please circle.

- Bleeding, sore gums (Yes/ No)
- Clenching/grinding? (Yes/ No)
- Clicking/popping jaw? (Yes/ No)
- Sensitive teeth (hot or cold)? (Yes/ No)
- Teeth sensitive to sweets? (Yes/ No)
- Orthodontic treatment (braces)? (Yes/ No)
- Deep cleanings (Scaling/root planning) (Yes/ No)

**Do you use the following?** Please circle.

(Yes/No) Toothbrush How often? \_\_\_\_\_ Manual or Electric?

Toothbrush type is: (Soft) (Medium) (Hard)

(Yes/No) Dental Floss? How often \_\_\_\_\_

Is there anything about your teeth you would like to change? \_\_\_\_\_

Do you want whiter teeth? \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Unless prior arrangements have been made, payment is expected at time of service. In order to provide the best possible service, please notify us at least 24 hours in advance if you are not able to keep an appointment. Broken appointments will be subjected to a charge.

I certify that the above information is true and accurate to the best of my knowledge. I accept full financial responsibility for my account, including any fees which are assessed to my account to collect any outstanding balance.



*Highland Dental Care*  
Compassionate Family Dentistry

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date



*Highland Dental Care*  
Compassionate Family Dentistry

**Electronic Consent**

We now have the ability to email and/or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign. Consent to Email and/or Text Message for Appointment Reminders, Statements and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications/information at that email and/or text from Fernandez Dental Care.

\_\_\_\_\_ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is (\_\_\_\_)- \_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ (Patient initials) I consent to emails, to receive communications as stated above. The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is \_\_\_\_\_

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Appointment Confirmation/Cancellation Policy**

We strive to provide the most compassionate family dental care to our patients. When an appointment is scheduled, that time has been reserved for you and when it is missed, that time cannot be used to treat another patient.



*Highland Dental Care*  
Compassionate Family Dentistry

**Our Policy is as follows:** Patients are required to confirm their appointment **48 hours** in advance through verbal verification, text verification or email at [hdconcepts01@gmail.com](mailto:hdconcepts01@gmail.com). Unconfirmed appointments are subject to being rescheduled. Cancellations will require a 48-hour notice.



*Highland Dental Care*  
Compassionate Family Dentistry

**Acknowledgement of receipt of notice of privacy practices**

\*You may refuse to sign this acknowledgement\*

I, \_\_\_\_\_, have received a copy of this office’s Notice of Privacy Practices.

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Authorization to release specific protected health information**

\*Per your request we are allowed to fax dental excuses to your school or business\*

\_\_\_\_\_  
Please print name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

For office use only

We attempted to obtain acknowledgement of receipt of our notice of privacy practices, but  
acknowledgement cannot be obtained because:

- Individual refused to sign
- communications barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement \_\_\_\_\_
- Other (please specify)

**Insurance Information Form**



*Highland Dental Care*  
Compassionate Family Dentistry

As a courtesy to you, we do accept copayments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. Regardless of what we might calculate as your copayment you are responsible for the TOTAL TREATMENT FEE. The estimate we make is based on limited information obtained from your insurance company. We allow 60 days for your insurance company to make payment. AFTER THIS TIME, ALL INQUIRIES (FOLLOW-UP) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

I authorize Leah Larson, D.D.S. and Kris Fernandez, D.D.S. to release any information including diagnosis and the records of any treatments or examination rendered to me or my child during the period of such dental care, to third party payors and/or other health care practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

*I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

---

Signature of patient or parent if minor

---

Date