Welcome to Junca Dental & Associates

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

1.- Patient Information

Confidential

(Please Print) S.S. # _____

Name _____ Birthdate _____ Home Phone _____
First M. Last

E-mail _____ Cell Phone _____

Address_____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Child ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is a student, Name of School/College _____ City _____ State _____

Who May We Thank for referring you? _____

Person to Contact in Case of an Emergency _____ Phone _____

2.- Responsible Party

Name of Person responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ S.S. # _____

Is this person Currently a Patient in our office? ☐ Yes ☐ No

3.- Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ S.S. # _____ Name of Employer _____

Insurance Company _____ Group # _____ Phone _____

4.- Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

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

I understand that the responsibility for payment for Dental Service provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

X _____
Signature of patient or parent if minor

5.- Financial Arrangements

For your convenience, we offer the following methods of payment:

■ Cash ■ Personal Check ■ Visa ■ MC ■ Am/Ex ■ Discover

Patient Signature _____ Date _____

Health History

Physician's Name _____

Address _____ Phone # _____

1. Have you taken any medicine or drugs during the past two years? YES NO

2. Are you now taking any medication, drugs or pills? YES NO

If yes, please list: _____

_____

3. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? YES NO

4. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Emphysema	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease or Attack	YES	NO	Cough	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Tuberculosis (TB)	YES	NO	Liver Disease	YES	NO
High Blood Pressure	YES	NO	Asthma	YES	NO	Yellow Jaundice	YES	NO
Heart Murmur	YES	NO	Hay Fever	YES	NO	Blood Transfusion	YES	NO
Rheumatic Fever	YES	NO	Sinus Trouble	YES	NO	Drug Addiction	YES	NO
Congenital Heart Lesions	YES	NO	Allergies or Hives	YES	NO	Hemophilia	YES	NO
Scarlet Fever	YES	NO	Diabetes	YES	NO	Venereal Disease:		
Artificial Heart Valve	YES	NO	Thyroid Disease	YES	NO	(Syphilis, Gonorrhea)	YES	NO
Heart Pacemaker	YES	NO	X-ray or Cobalt Treatment	YES	NO	Cold Sores	YES	NO
Heart Surgery	YES	NO	Chemotherapy	YES	NO	Fever Blisters	YES	NO
Artificial Joins (Hip, Knee)	YES	NO	Arthritis	YES	NO	Epilepsy or Seizures	YES	NO
Anemia	YES	NO	Rheumatism	YES	NO	Fainting or Dizzy Spells	YES	NO
Stroke	YES	NO	Cortisone Medicine	YES	NO	Nervousness	YES	NO
Kidney Trouble	YES	NO	Glaucoma	YES	NO	Psychiatric Treatment	YES	NO
Ulcers	YES	NO	Pain in Jaw Joints	YES	NO	Sickle Cell Disease	YES	NO
Cosmetic Surgery	YES	NO	A.I.D.S.	YES	NO	Bruise Easily	YES	NO
Do you use any recreational Drugs (Cocaine, LSD, Marijuana, Etc.)				YES	NO			
Are you allergic to any metals (Copper, Silver, Gold, Etc.)				YES	NO			

FOR WOMEN ONLY:

Are you pregnant? YES NO if Yes, What Trimester? _____ Are you taking birth control pills? YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

The undersigned hereby authorizes the doctor to the take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy. I also understand the use of anesthetic agents embodies a certain risk. I know the practice of dentistry is not an exact science and that therefore, reputable practitioners cannot guarantee results. No guarantee or assurance has been given by anyone as to the result that may be obtained.

Patient Signature _____ Date _____

Parent of Responsible Party _____ Relationship to Patient _____

_____ _____

Date Signature of Dentist

Medical history update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Junca Dental & Associates

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OFFICE POLICIES

(Please read and sign)

THE INVESTMENT necessary to complete your treatment is based on an estimate derived from our examination. Should additional unforeseen problems arise as treatment progresses, this estimate may have to be revised. You will be consulted before any unexpected treatment is undertaken. This estimate will be honored provided treatment is completed within three (3) months of the date of the initial examination (by Junca Dental & Associates).

MISSED APPOINTMENTS: No charge will be made for rescheduling an appointment provided 24 hours notice is given, otherwise a minimum charge of $50 per half hour missed will be made. Please remember that once an appointment has been made, that this time has been reserved specifically for YOU.

RETURNED CHECKS: There will be a $35 handling fee for any returned checks.

THERE IS a $25.00 fee for duplication of x-rays.

ACCEPTANCE OF INSURANCE ASSIGMENTS: As courtesy to patients, this office accepts insurance assignments, but this does not absolve the patient of responsibility for charges in full for the treatment rendered. The estimate provided by this office is to be considered a guideline until the final insurance payment is received and the patient's account reconciled. This office can make no guarantee of the insurance payment as estimated.
If the account has been overpaid for ANY reason and requires return of any monies, this will be done using the format that was used for payment with the exception of cash which will be returned in the form of a company check.

ATTORNEY'S FEES AND COLLECTION FEES: Any fees incurred by this office in collecting a delinquent account will be charged to the patient whose failure to make payments as specified in this agreement necessitated said costs.

FAILURE to sign this service contract does not negate the patient's financial responsibility for any services that have already been rendered as submission to treatment implies consent.

FINALLY, upon signing this contract, it is agreed that you will be responsible for all services rendered.

Signature _____ Date _____