CITY DIFFERENT DENTISTRY
444 St Michael's Dr, Suite B, Santa Fe, NM 87505
(505) 989-8749

PATIENT INFORMATION

Name _____ Birthdate _____
Social Security Number _____
Mailing Address (street) _____
City _____ State _____ Zip _____
Home Address _____
Home Phone _____
Work Phone _____
Cell Phone _____ Best time to reach you? _____
Email Address _____
Your Occupation _____ Employer _____
Spouse's Name _____
Work Phone _____
Spouse's Social Security Number _____
Legal Guardian or Parent Name (if patient is a child) _____
Phone _____
Person other than spouse to be notified in case of an emergency _____
Phone _____
Medical Physician _____ Phone _____

HEALTH HISTORY

This information will be confidential and is necessary to allow us to give you our best treatment. Please check yes or no to whether you have or haven't had any of the following:

YES	NO		YES	NO	
____	____	Heart problems	____	____	Heart murmur
____	____	High or low blood pressure	____	____	Pain, pressure, tightness in chest
____	____	Radiation treatments	____	____	Circulatory problems
____	____	Blood transfusion (date)	____	____	Rheumatic fever
____	____	HIV+, AIDS or exposure to AIDS	____	____	Periodontal disease
____	____	Venereal Disease	____	____	Bleeding gums
____	____	FEMALES: currently pregnant	____	____	Malignancies/Cancer
		(check yes if the possibility exists)	____	____	Sinus problems
____	____	Antidepression medication	____	____	Temporomandibular dysfunction
____	____	Psychiatric care or psychotherapy	____	____	Cold sores
____	____	Nervous problems	____	____	Herpes
____	____	Ulcer	____	____	Thyroid problems
____	____	Stroke	____	____	Excessive bleeding
____	____	Anemia	____	____	Diabetes
____	____	Arthritis	____	____	Hepatitis A, B or C, Jaundice (date _____)
____	____	Epilepsy	____	____	Kidney or bladder disease
____	____	Artificial joints	____	____	Lung problems (T.B., asthma, emphysema)

Other, if so, what: _____
_____
_____

Do you have or have you had allergic reactions to the following:

YES	NO		YES	NO	
____	____	Penicillin	____	____	Codeine
____	____	Tetracycline	____	____	Latex/Vinyl
____	____	Erythromycin	____	____	Dental anesthetics
____	____	Tylenol	____	____	Other, if so, what: _____
____	____	Aspirin			_____
____	____	Ibuprofen			

Do you need to be pre-medicated for any medical condition? yes ____ no ____ not sure ____
Are there any other medical conditions we should know about? _____
_____
Are you or have you ever taken cortisone? _____
Do you use tobacco? _____ What kind? _____
Do you take any herbal remedies? yes ____ no ____ If yes, what? _____
Date of last dental exam: _____ and cleaning: _____
Have you had any problems with previous dental treatment? yes ____ no ____
If yes, explain: _____
_____
Are you interested in improving your smile? yes ____ no ____ If yes, how? _____
_____

Please list ALL medications you are currently taking:

WHAT MEDICATIONS:	REASON FOR:
_____	_____
_____	_____
_____	_____
_____	_____

Please list all hospitalizations: _____
_____
If yes, explain: _____
_____
Whom may we thank for referring you? _____

To the best of my knowledge the above information is complete and correct. I understand that I am responsible for payment in full at the time of service.

Patient or guardian signature: _____
Date: _____

INFORMATION AND CONSENT

We would like you, our patient, to be fully informed about the various procedures involved in your treatment and we will require your written consent before starting treatment.

GENERAL RISKS OF DENTAL CARE: Included (but not limited to) are complications resulting from the use of dental instruments and medications such as: antibiotics, analgesics (pain medications), and local anesthetic injections. These complications may include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head, nausea, vomiting, allergic reactions; delayed healing; sinus perforations and treatment failure.

SPECIFIC RISKS: The treatment that we have recommended, [Inlay/Onlay, Crown, Bridge] is intended to correct conditions in your mouth that can ultimately lead to worsening complications or tooth loss. During treatment, complications may be discovered which make treatment impossible, or which may require corrective dental surgery. These complications may include exposure of your tooth pulp or fractures of the teeth. Usually these complications are due to the condition of the gums and/or bone or previous restorations and cannot be foreseen either by clinical or radiographic examination.

MEDICATIONS: Some prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced buy the use of alcohol, tranquilizers, sedatives or other drugs.) It is not advisable to operate any vehicle or hazardous device until recovered from their effects. Some antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Women who are taking oral contraceptives, and are given a prescription for an antibiotic, are strongly advised to use additional means of birth control during the entire monthly cycle for which the antibiotic has been used.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, and tooth extraction. Risk involved in these choices may include pain, infection, swelling, loss of teeth, and spread infection in other areas. The risks of these alternative treatments are often more severe than those of root canal therapy.

CONSENT: *I the undersigned, being the patent (parent or guardian of patient) consent to performing the procedures decided to be necessary or advisable in the opinion of the doctor. I understand that this treatment is an attempt to save a tooth, and that even though this therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had previous treatment may require re-treatment, corrective surgery or even extraction.*

I hereby state that I have read and understand this consent. I have been given the opportunity to question the doctor, and all questions about the procedure(s) have been answered in a complete and satisfactory manner. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment.

Patient/Representative Initial _____ **Date** _____

REFERRAL DISCLAIMER

Any referral to another professional is provided as merely a convenience to you. This office may provide references to other practitioners but Jade Vigil, DDS, has not reviewed these other facilities or practitioners, has no responsibility for the services provided by such other practitioners and shall not be liable for any damages or injury arising from their services. You understand that, except for the information or services clearly identified as being supplied by Jade Vigil, DDS, this office does not operate, control or endorse any information, products or services provided by another practitioner or practice in any way. Jade Vigil, DDS, does not endorse or make any representations about any practitioner or practice it refers, or any information or other products or materials found through such practice, or any results that may be obtained from using these practitioners or the services or products they provide. If you decide to utilize any of these referred practitioners and the services and products they provide, you do so entirely at your own risk.

Patient/Representative Initial _____ **Date** _____

City Different Dentistry
444 St Michaels Dr, Suite B | Santa Fe, NM 87505 | (505) 989-8749

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that City Different Dentistry may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

City Different Dentistry has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, City Different Dentistry will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow City Different Dentistry to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that City Different Dentistry has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: City Different Dentistry, 444 St Michaels Dr Suite B, Santa Fe, NM, 87505. (505) 989-8749.

We attempted to obtain a written Acknowledgement of Receipt of our Notice of Privacy Practice but we were unable doe to:

[ ] The patient (or person representative) refused to sign

[ ] Inability to communicate (communication problems)

[ ] Emergency situation

[ ] Other:

Privacy Officer: Miranda Montoya

_____ _____

Signature of Officer **DATE**

PRIVACY NOTICE (NOTICE OF PRIVACY PRACTICES)

Dr. Jade Vigil
444 St Michaels Dr, Suite B | Santa Fe, NM 87505 | (505) 989-8749

City Different Dentistry
444 St Michaels Dr, Suite B | Santa Fe, NM 87505 | (505) 989-8749

Required Addendum to our NPP (Notice of Privacy Practices)

Special Privacy Protections for Certain Health Information
We are **not primarily a substance use disorder (SUD) treatment program. We may receive and maintain SUD-related information incidentally** (e.g., referrals, history, meds, labs) and that information we maintain may be subject to additional federal privacy protections, including records related to the diagnosis, treatment, or referral for treatment of a substance use disorder. These records are protected by federal law (42 C.F.R. Part 2), which, in some cases, is more restrictive than HIPAA. When these stricter rules apply, we follow them.

How We May Use and Disclose Health Information
We may use and disclose your health information for treatment, payment, and health care operations. When information includes substance use disorder records, additional legal requirements may apply, including your written consent before using or disclosing that information.

Limits on Use of Substance Use Disorder Records
Federal law places **strict limits** on how substance use disorder records may be used or disclosed. Substance use disorder records cannot be used or disclosed to initiate or substantiate civil, criminal, administrative, or legislative proceedings without written consent or a qualifying court order.

Authorization and Consent
Certain uses and disclosures require written authorization. You may revoke authorization at any time by written reques, except where already relied upon. If your health information includes substance use disorder records, your authorization may allow us to use and disclose that information for **treatment, payment, and health care operations**, as permitted by law.

Your Rights Regarding Your Health Information
You have rights to inspect, access, amend, request restrictions, request confidential communications, and receive an accounting of disclosures, as permitted by law.

Redisclosure Notice
If your health information is disclosed to another party, that party may be permitted to **redisclose** the information, and it may no longer be protected by HIPAA. However, **substance use disorder records** may continue to be protected by federal law even after disclosure, depending on the circumstances.

Public Health and De-Identified Information
We may disclose **de-identified health information** for public health, research, or health care operations purposes as permitted by law. De-identified information does not identify you and cannot reasonably be used to identify you.

Fundraising Communications
We may contact you for **fundraising purposes**. You have the right to **opt out** of receiving fundraising communications at any time. Your decision to opt out will **not affect your access to care**.

Complaints and Enforcement
If you believe your privacy rights have been violated, you may file a complaint with us or with the **U.S. Department of Health and Human Services**. You will not be retaliated against for filing a complaint.

Changes to This Notice
We reserve the right to change this Notice of Privacy Practices at any time. Any changes will apply to all health information we maintain. The current version of this Notice will be available upon request and on our website.

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Missed Appointment Policy

Your appointment time is reserved just for you and the doctor and the office staff are standing by. Please respect out time and resources by always keeping your appointment.

If you cannot come to your scheduled appointment, we require a 48 hour notice so we can fill that appointment time with another patient.

If we have less than 48 hours notice, or if you fail to show for your scheduled appointment without giving any noice, we reserve the right to charge a $50 no show fee. This fee is to be paid when you schedule your next appointment.

If there are two missed appointments in a 12-month period, the no show fee will increase to $75.

Repeated missed appointments will result in dismissal from the practice.

Thank you for being our patient, we value your time and your health and we look forward to seeing you at all your scheduled appointments.

_____ _____

SIGNATURE **DATE**

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Photo Release Form

I hereby agree and consent to allow the practice of City Different Dentistry to use my before and after smile photos, in any form of advertising, print, web, etc. and I do not expect any compensation for this usage.

_____ _____

SUBJECT SIGNATURE **DATE**

_____ _____

SUBJECT PRINTED NAME **PHONE NUMBER**

City Different Dentistry
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Dental Work Warranty

Limited Conditional Warranty:

The treatment provided to you in our office carries a limited and conditional warranty. This warranty requires you, our patient, to meet some conditions. Please see the conditions as follows:

- You, the patient, agrees to schedule and attend regular recall appointments at our office every six months. Our recall appointments can include hygiene maintenance, doctor exams, and either a series of bitewing x-rays, or a full mouth series of x-rays depending on which is due. Recall appointments at another dentist do not count towards this condition.

- This limited warranty covers the quality of the doctor's work only, and does not apply to damage resulting from patient neglect, failure to wear a guard appliance if recommended, failure to attend regular recall appointments, or abuse of the restoration. Some of the materials used for restoration are subject to breakage the same as natural teeth. We will recommend a night guard for those patients that present with bruxism or other grinding or clenching problems. Full fees will be charged for any repair or replacement of dental work resulting from bruxism if the recommended guards are not used.

If your restoration fails clinically and you have not adhered to the above terms, you will be charged the full fee to replace the restoration.

If the above conditions have been met our office will redo or repair the restoration for no charge for up to one year after the treatment has been completed.

_____ _____

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Informed Consent for Dental Restoration

I understand that one or more of my teeth have been recommended to be treated with an extraction, root canal, full crown, bridge, onlay, inlay or veneer. These restorations are generally used to repair teeth that have been structurally compromised by decay or previous restorative work. They may also be used to improve the cosmetic aspect of my smile, change my occlusion or to protect a tooth.

I understand that my tooth/teeth will be prepared to receive the restoration. This will require the removal of some of the existing tooth structure with a high-speed dental bur. There is a possibility the tooth may be sore or uncomfortable for a while after the preparation procedure but this will subside after a period of time. On occasion the pulp may be irritated in the preparation process and may begin to hurt. If the pain persists, the tooth may need a root canal treatment or possibly an extraction.

An impression will be taken of my mouth before preparation begins, as well as after the preparation is complete. These will be sent to a lab which will fabricate a restoration specifically designed to fit my teeth. The impression will also be used to make the temporary restoration. It usually takes two to three weeks for the lab to complete their work, during which time I will have the temporary restoration, or “temp" as we call it. Temps are designed to last a short period of time, but in certain circumstances that time frame can be extended. It is important to return to the office when scheduled to receive your permanent restoration as to avoid problems caused by the quality of the temp diminishing over time.

When the permanent restoration is in place, I will be give the opportunity to confirm that the color and appearance is to my liking. After checking proper fit, the permanent restoration will be cemented to my tooth. Additional adjustments will be made at that point to ensure that my bite is comfortable.

Though the restorations are made of materials that will not decay, I understand that I must still care for them as if they were natural teeth. Brushing and flossing regularly and attending regular dental checkups and cleanings will minimize the chances of decay forming where the restoration material meets the natural tooth as well as preventing gum disease.

I have been given the opportunity to ask questions and express concerns. By signing this form I am giving my consent to authorize my doctor and staff to render any services they deem necessary or advisable to my individual treatment. I acknowledge that I have been informed that all restorative dental work done by our office has no replacement guarantee unless I am seen by the office for a check up every six months at minimum. If that condition is met, I understand I will have a replacement warranty on my dental work that will last for one year after delivery of the restoration.

_____ _____

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Informed Consent for Anesthesia

I, the undersigned patient, hereby give my consent for the undersigned provider and/or any one of the qualified staff to administer a local anesthesia prior to the dental procedure(s) or course of treatment recommended.

I understand the risks inherent in anesthesia and acknowledge that they may include, but are not limited to: allergic reaction, infection, bleeding, phlebitis (irritation of vein), nausea, blood clots, loos of limb function, paralysis, stroke, heart attack, brain damage or death. I have accurately filled out my medical history form listing any medications or conditions that I might be taking or currently have in order to reduce the risk of complications. I have also informed the assistant, treatment plan coordinator or practitioner of any recreational drug usage.

If nitrous oxide is recommended or provided to me at my request, I hereby give permission for the doctors and staff to perform nitrous oxide sedation. I understand that the administration of medication and the performance of conscious sedation with nitrous tide carries certain common hazards, risks and potential unpleasant side effects which are infrequent, but may occur. They include but are not limited to: excessive sweating, behavioral problems (excessive talking, vivid dreams, excessive laughing), shivering, Nausea, and vomiting.

I have been given the opportunity to ask questions and express any concerns I have about the anesthesia and my questions/concerns have been addressed appropriately. I confirm that I understand this form and the information contained herein.

_____ _____

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Financial Policy

Your dental care is our primary objective. Our relationship depends on your clear understanding of our financial policy as well as of your own insurance plan, if applicable.

Payment is due at time of service. *If you have If you have other forms of insurance other than Delta Dental PPO*, as a courtesy to you, we will submit your claims. It is your responsibility to be familiar with your own policy. If you have questions or confusion, please call your insurance company directly so that there are no surprises.

We only have contracts with Delta Dental PPO Insurance. For other insurance companies we ask you to pay the full amount of the day's services as well as gross receipts tax after your appointment.

Once we send out a claim, insurance companies are required by law to make a determination on it within 45 days of receiving it. You will then be notified of any balance that is due. We expect payment of that balance within 30 days of notification. Your dental insurance is a contract between you and your insurance company, not this office. We will not become involved in disputes between you and your insurance company other than to supply factual information as needed.

We accept the following forms of payment: cash, checks, all major credit cards as well as the Care Credit health care credit card. If you have questions about applying for Care Credit, please see our front desk staff.

Other Service Charges:

∗18% Annual (1.5% monthly) interest is charged to accounts with outstanding balances 60 days from date of service.
∗Returned checks are subject to a $25 service charge.

I have read this policy statement and hereby agree to the conditions herein:

_____ _____

PATIENT SIGNATURE **DATE**