BOCA MISSION BAY DENTISTRY

Chart #:

		Pati	ient Information			
Patie	ent Name:				Date:	
	Last Male D Female	Firs Married		MI	Date	
	al Security #:					
Phon	le (Home):	(Work):	Ext:	(Cell):		
11	il address:					
	ess:					
	Street				Apartment #	
	City		State		Zip Code	
		D				
	llowing is for: the patient's spous	Spouse or Kes e the person respo	ponsible Party Ir	nformation		
Name	e: Male	1	Married D Single D	Child Oth	ner	
Socia	al Security #:		Birth Date:	Offild 2 Ott.	lei	
Phon	e (Home):	(Work):	Ext:	(Cell):		
	ess:		CAU			
	Street	-59			Apartment #	
	City			late	Zip Code	
		Emplo	yment Information	on.		
11	lowing is for: the patient	the person respon	nsible for payment			
	oyer Name:		Occupation	:		
	ce.					
	Street		City	State	7:- 0-4-	
	Street		City	State	e Zip Code	
Primar	Street	Insura	ance Information	1		
Primar Name	y e of Insured:	Insura	ance Information	ls insured	a patient? □ Yes □ N	0
Primar Name Insure	y e of Insured: Last ed's Birth Date:	Insura	ance Information	ls insured	a patient? □ Yes □ N	0
Primar Name Insure	Street Y e of Insured: ed's Birth Date: ed's Address: Street	Insura ID#:	City Ance Information MI City	l s insured Group #:	a patient? □ Yes □ No	0
Primar Name Insure	ed's Address: Street Street Street Street Street Street Street	Insura ID#:	City Ance Information MI City	ls insured	a patient? □ Yes □ No	0
Primar Name Insure	Street Y e of Insured: ed's Birth Date: ed's Address: Street	Insura ID#:	City ance Information MI City	I Is insured Group #:	a patient? □ Yes □ No e Zip Code	0
Primar Name Insure Insure	ed's Birth Date: Ed's Address: Ed's Employer Name: Address: Street	Insura ID#:	City Ance Information MI City City	I Is insured Group #: State	a patient?	0
Primar Name Insure Insure	of Insured: ed's Birth Date: ed's Address: Address: Street Street Attreet	Insura First ID #: Self □ Spouse □	City MI City City City Child Other	Is insured Group #: State	a patient? □ Yes □ No e Zip Code	0
Primar Name Insure Insure	ed's Birth Date: Ed's Address: Ed's Employer Name: Address: Street	Insura First ID #: Self □ Spouse □	City MI City City City Child Other	I ls insured Group #: State	a patient? □ Yes □ No e Zip Code	0
Primar Name Insure Insure Insure	e of Insured: ed's Birth Date: ed's Address: ed's Employer Name: Address: Street ot's relationship to insured: ance Plan Name and Address: dary	Insura First ID #: Self □ Spouse □	City MI City City City Child Other	I s insured Group #: State	a patient? □ Yes □ No	
Primar Name Insure Insure Insure Patien Insura Second Name	of Insured: Ed's Birth Date: Ed's Address: Ed's Employer Name: Address: Street ot's relationship to insured: Ince Plan Name and Address: dary of Insured: Last	Insura First ID #: Self □ Spouse □ First	City MI City City Child Other	Is insured Group #: State	a patient? □ Yes □ No	
Primar Name Insure Insure Insure Patien Insura Second Name Insure	ed's Birth Date: ed's Address: ed's Employer Name: Address: Street ot's relationship to insured: ance Plan Name and Address: dary of Insured: ed's Birth Date:	Insura Insura Insura First ID#: ID#:	City MI City City Child □ Other	Is insured Group #: State	a patient? □ Yes □ No	
Primar Name Insure Insure Insure Second Name Insure Insure	ed's Birth Date: ed's Address: ed's Employer Name: Address: Street ot's relationship to insured: ance Plan Name and Address: dary of Insured: ed's Birth Date:	Insura Insura Insura First ID#: ID#:	City MI City City City MI MI MI MI MI MI MI	Is insured Group #: State	a patient? Yes No	
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Referral Information								
Whom may we thank for referring you to our practice? □Another patient, friend □Another patient, relative □ Dental Office □ Yellow Pages □ Newspaper □ School □ Work □ Other								
Name of person or office referring you to our practice:								
	Health	Information						
Date of Last Dental Visit: Reason for this visit:								
Have you ever had any of t	Have you ever had any of the following? Please check those that apply:							
□ HIV	☐ Excessive Bleeding	☐ Mental Disorders	□Penicillin Allergy □ Codeine Allergy					
□ AIDS	☐ Fainting	☐ Nervous Disorders	☐ Tumors					
□ Allergies	☐ Glaucoma	☐ Pacemaker	□ Ulcers					
	☐ Growths	☐ Pregnancy Due date:	☐ Venereal Disease					
□ Anemia	☐ Hay Fever ☐ Head Injuries	□ Radiation Treatment	OTHER:					
☐ Arthritis	☐ Heart Disease	□ Respiratory Problems						
☐ Artificial Joints	☐ Heart Murmur	☐ Rheumatic Fever						
☐ Asthma ☐ Blood Disease	☐ Hepatitis	☐ Rheumatism						
□ Cancer	☐ High Blood Pressure	☐ Sinus Problems						
□ Diabetes	□ Jaundice	☐ Stomach Problems						
☐ Dizziness	☐ Kidney Disease	☐ Stroke						
□ Epilepsy	☐ Liver Disease	☐ Tuberculosis						
	nplications following dental tre							
Have you been admitted to If yes, please explain:		ncy care during the past two yea	ars? 🗆 Yes 🗆 No					
	e of a physician? Yes	No						
Do you have any health pro If yes, please explain:	oblems that need further clarif	ication?						
Please list any medications	you may be taking. Including o	over the counter						
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.								
Signature of patient, parent or gu	ardian		Date					
	Consen	t for Services						
I have answered all questions truthfully and to the best of my knowledge. I hereby authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis. I also understand the use of anesthetic agent embodies a certain risk.								
As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.								
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.								
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. In addition, I agree that should this account be referred to an agency or attorney for collection that I shall be responsible for all collection costs, attorneys fees, and court costs. I further agree to a charge of \$35.00 for returned checks.								
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.								
Date: Relationship to Patient:								
Signature of patient, parent or gua	Signature of patient, parent or guardian							
Signature of guarantor of payment		: Relationship to P	auent:					

BOCA MISSION BAY DENTISTRY DENNIS F. SIERRA, D.M.D., P.A.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

have reviewed/received a conv of

Patient Name		
DENNIS F. SIERRA, D.M.D., P.A. Practice Name	's Notice of Privacy Practices.	
Signature of Patient / Guardian	Date	
OFFICE USE attempted to obtain the patient's signature in acknown cknowledgement, but was unable to do so as docum	wledgement on this Notice of Privacy Practice	∋s

Reason:

Initials:

Date:

BOCA MISSION BAY DENTISTRY

Chart #:
FOR OFFICE USE ONLY

	Patient I	nformation				
Patient Name:				Date:		
Last Male □ Female	First ☐ Married ☐ S	Single	MI Other			
Social Security #:						
Phone (Home):(Work):	Ext:	(Cell):			
e-mail address:						
Address:						
Street				Apartment	#	
City		State		Zip Code		
The following is for: the patient's spouse Name:						
Name: Male D Female	☐ Marrie					
Social Security #:						
Phone (Home):(Work):	Ext:	(Cell):			
Address: Street				Apartr	ment #	
City		S	late	Zij	p Code	
The following is for: the patient	Employme the person responsible f	nt Information	on			
Employer Name:			1:			
Zimpio) or realitie.		THE REAL PROPERTY AND ADDRESS OF THE PERTY				
Address:						
Address:	Cit				Zip Code	
Street	Cit	Information	s n	tale		
Primary Name of Insured:	Insurance	Information	s n	tale		□ No
Street	Insurance	Information	n Is insure	ed a patient		
Primary Name of Insured: Insured's Birth Date: Insured's Address:	Insurance	Information	n Is insure _ Group #:_	ed a patient	t? □ Yes	
Primary Name of Insured: Insured's Birth Date:	Insurance First ID #:	Information	n Is insure _ Group #:_	ed a patient	t? □ Yes	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name:	Insurance First ID #:	e Information	n Is insure _ Group #:_ s	ed a patient	t? □ Yes	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Address: Street Street	Insurance Insurance	e Information MI City	n Is insure _ Group #:_ s	ed a patient	t? □ Yes	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Address: Street Patient's relationship to insured:	Insurance Insurance ID#:	City City City City City	n Is insure _ Group #:_ s	ed a patient	t? □ Yes	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Address: Street Street	Insurance Insurance ID#:	City City City City City	n Is insure _ Group #:_ s	ed a patient	t? □ Yes	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Address: Street Patient's relationship to insured:	Insurance Insurance ID#:	City City City Colty	n Is insure _ Group #:_ s	ed a patient	t? □ Yes Zip Code	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Address: Street Patient's relationship to insured: Insurance Plan Name and Address: Secondary Name of Insured:	Insurance Insurance Insurance First ID#: elf □ Spouse □ Ch	City City City MI	n Is insure Group #:_ s Is insure	ed a patient	t? □ Yes Zip Code Zip Code	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Address: Street Patient's relationship to insured: Insurance Plan Name and Address:	Insurance Insurance Insurance First ID#: elf □ Spouse □ Ch	City City City MI	n Is insure Group #:_ s Is insure	ed a patient	t? □ Yes Zip Code Zip Code	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Address: Street Patient's relationship to insured: Insurance Plan Name and Address: Secondary Name of Insured: Insured's Birth Date: Insured's Address: Street	Insurance Insurance ID#: ID#: ID#:	City MI City MI City City City City City	Is insure Group #:_ Is insure	ed a patient	t? □ Yes Zip Code Zip Code	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Address: Street Patient's relationship to insured: Insurance Plan Name and Address: Secondary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Sireet Insured's Employer Name:	Insurance Insurance ID#: ID#: ID#:	City MI City MI City City City City City	Is insure Group #:_ Is insure	ed a patient	t? □ Yes Zip Code Zip Code	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Address: Street Patient's relationship to insured: Insurance Plan Name and Address: Secondary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Address: Insured's Employer Name: Address: Street Street Street Address: Street	Insurance Insurance ID#: ID#: First ID#:	City City City City City City	Is insure Group #:_ Is insure Group #:_	ed a patient State	t? □ Yes Zip Code Zip Code	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Address: Street Patient's relationship to insured: Insurance Plan Name and Address: Secondary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Sireet Insured's Employer Name:	Insurance Insurance ID#: ID#: First ID#:	City City City City City City	Is insure Group #:_ Is insure Group #:_	ed a patient State	t? □ Yes Zip Code Zip Code	
Primary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Address: Street Patient's relationship to insured: Insurance Plan Name and Address: Secondary Name of Insured: Insured's Birth Date: Insured's Address: Insured's Address: Insured's Employer Name: Address: Street Street Street Address: Street	Insurance Insurance Insurance ID#: ID#: ID#: ID#: ID#:	City City City Id Other MI City City	Is insure Group #:_ Is insure Group #:_	ed a patient State State State State	t? □ Yes Zip Code Zip Code	



BOCA MISSION BAY DENTISTRY

\$35.00 if I do not give at least a 24 hour notice	nd that there will be a charge of ce before canceling an appointment.
Our office takes pride in always spending qu	ality time with our national Man
not to double book appointment time slots in his time needed to care for each patient.	order to allow Dr. Sierra to spend
Unfortunately, this policy has to be implement patients have confirmed their appointment are leaves time in the schedule that Dr. Sierra cowho are sometimes waiting days or even well	nd then have not shown up. This buld be spending with other nations.
Thank you for your understanding in this mat	ter.
Signature of Patient or Legal Guardian	Date

Referral Information Whom may we thank for referring you to our practice? □ Dental Office □ Yellow Pages □ Newspaper □ School □ Work □ Other Name of person or office referring you to our practice:							
The state of the s							
Health Information							
Date of Last Dental Visit: Reason for this visit:							
Have you ever had any of the following? Please check those that apply:							
□ HIV □ AIDS	☐ Excessive Bleeding	☐ Mental Disorders	□Penicillin Allergy				
□ Allergies	☐ Fainting ☐ Glaucoma	☐ Nervous Disorders ☐ Pacemaker	☐ Codeine Allergy				
- Allergies	☐ Growths	□ Pregnancy	☐ Tumors ☐ Ulcers				
□ Anemia	☐ Hay Fever	Due date:	□ Venereal Disease				
☐ Arthritis	☐ Head Injuries	□ Radiation Treatment	OTHER:				
☐ Artificial Joints	☐ Heart Disease	□ Respiratory Problems					
☐ Asthma	☐ Heart Murmur	□ Rheumatic Fever					
☐ Blood Disease	☐ Hepatitis	☐ Rheumatism					
□ Cancer	☐ High Blood Pressure	☐ Sinus Problems					
□ Diabetes	☐ Jaundice	☐ Stomach Problems					
□ Dizziness	☐ Kidney Disease	Stroke					
EpilepsyHave you ever had any compli yes, please explain:	☐ Liver Disease						
Have you been admitted to a If yes, please explain:	hospital or needed emerger	ncy care during the past two year	rs? 🗆 Yes 🗆 No				
Are you now under the care If yes, please explain:	of a physician? Yes N	lo					
		Phone:					
Do you have any health prob If yes, please explain:		cation? ☐ Yes ☐ No					
Please list any medications yo							
To the best of my knowledge, any change in my health, I will		and information provided are tru t appointment without fail.	e and correct. If I ever have				
Signature of patient, parent or guard	Signature of patient, parent or guardian Date						
	Consent	for Services					
I have answered all questions truthfully and to the best of my knowledge. I hereby authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis. I also understand the use of anesthetic agent embodies a certain risk.							
As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.							
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.							
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.							
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. In addition, I agree that should this account be referred to an agency or attorney for collection that I shall be responsible for all collection costs, attorneys fees, and court costs. I further agree to a charge of \$35.00 for returned checks.							
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.							
Signature of patient, parent or guardia	Date: Relationship to Patient:						
Date: Relationship to Patient:							
Signature of guarantor of payment/responsible party							