GARCES DENTAL GROUP
MEDICAL HISTORY ASSESMENT FORM

In order for us to provide you with effective and safe dental care, we need to understand some basic information about your past and present health. Please answer these as best as you can. Your responses will be reviewed by the dentist. Circle the following yes or no which describes your history for questions that implicate yes or no answers. Use a question mark when you don't understand a question or are not sure of your answer.

Today's Date/ Fecha: _____ Last Name/ Apellido: _____

First Name/ Nombre: _____ Middle Initial/Inicial (2do nombre): ____

Birth Date/Fecha de Nacimiento: _____ Age/Edad: _____ Sex/Sexo: _____

Marital Status/Status : Single/Soltero (a): _____ Married/ Casado (a): _____
Partnership/ Unión de hecho: _____ Divorced/Divorciado(a): _____

Social Security Number/Seguro Social: _____

Insurance/Aseguradora: _____Employer Name/Patrono: _____

Home Address/Dirección:_____

City/Ciudad: _____ State/Estado: _____ Zip Code/Código Postal:_____

Home Phone/ Teléfono Casa: _____ Cell/Celular: _____Other/Otro: _____

Best time to reach you?/Mejor horario para localizarlo(a) _____

Email Address/Correo Electrónico:_____

Whom may we thank for referring you?/Quién lo refirió? _____

Previous/Present Dentist/Dentista anterior/presente_____

Last visit date/Fecha de su última visita: _____

Emergency Contact Name and Number/Teléfono y contacto de emergencia:
_____

My current physical health is?/Mi salud actual es
Good/Buena Fair/Regular Poor/Mala

Are you taking any prescription or over the counter supplement drugs? Please list each/ Toma alguna medicina prescrita o medicina sin prescripción? Liste cada una:

_____

_____

Do you smoke or use tobacco in any other form?/Fuma? Yes/Si No
Have you ever taken Phen-fen? (Also known as Redux, or Pandimin)/Alguna vez a tomado Phen-Fen (Conocido también por Redux or Pandimin): Yes/Si No

(For Women)/(Para mujeres):Are you taking birth control pills?/Toma anticonceptivos?
Yes/Si No

Are you pregnant?/Esta embarazada Yes/Si No (Week #/No.semana _____)

Are you nursing?/Esta en etapa de lactancia Yes/Si No

Are you allergic to any of the following (please circle if any apply to you)/Es alérgico a alguna de estas medicinas:

ASPRIN/ASPIRINA	**ERYTHROMYCIN/ERITROMICINA**	**PENICILLIN/PENICILINA**
CODEIN/PENICILINA	**JEWERLY/METAL- JOYAS/METALES**	**TETRACYCLIN/TETRACICLINA**
LATEX	**DENTAL ANESTHETICS/ANESTESICOS DENTALES**	**OTHER/OTRO_____**

Please List any other drugs or materials that you are allergic to:/Liste medicinas o materiales a los que sea alérgico(a):

DO YOU HAVE OR HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?/ TIENE, HA TENIDO O HA SIDO DIAGNOSTICADO CON ALGUNA DE ESTAS ENFERMEDADES?

Y N Anemia / Radiation Treatment/Anemia/Tratamientos de Radiación
Y N Hemophilia / Abnormal Bleeding - Hemofilia/Sangrado Abdominal
Y N Artificial bones / joints / valves - Huesos artificiales/articulaciones/ válvula
Y N Hepatitis
Y N Artritis
Y N High / Low Blood Pressure - Presión arterial Alta/Baja
Y N Asthma - Asma
Y N HIV / Aids - HIV/Sida
Y N Blood Transfusion - Transfución sanguínea
Y N Hospitalized for any reason? - Ha sido hospitalizado (a) por alguna razón?
Y N Bleeding Disorders - Desordenes de sangrado
Y N Kidney Problems - Problemas renales
Y N Bacterial Endocarditis - Endocarditis Bacterial
Y N Mitral Valve Prolapse - Prolápso de la Válvula Mitral
Y N Cancer / Chemotherapy - Cancer/Quimioterapia
Y N Psychiatric problems - Problemas psiquiátricos
Y N Congenital Heart Defects - Defectos cardiácos congénitos
Y N Rheumatic /Scarlet Fever - Fiebre reumática/Escarlatina
Y N Diabetes
Y N Severe / Frequent Headaches - Dolores de cabeza severos/frecuentes
Y N Difficulty Breathing - Dificultad para respirar
Y N Shingles - Herpes Sosta
Y N Drug / Alcohol Abuse - Abuso de drogas/alcohol
Y N Sickle Cell Disease /Traits - Enfermedad Depranocitica
Y N Emphysema / Glaucoma - Efisema/Glaucoma
Y N Sinus Problems - Sinusitis
Y N Epilepsy / Seizures / Fainting spell - Epilepsia/Convulsiones/Desmayos
Y N Tuberculosis (TB) - Tuberculosis
Y N Fever Blisters / Herpes
Y N Ulcers / Colitis - úlceras/colitis
Y N Heart Attack / Stroke - Infarto
Y N Venereal Disease - Enfermedades venereas
Y N Heart Murmur - Soplo en el corazón
Y N Shunts or Ports/Sondas o vábulas
Y N Heart Surgery / or Pacemaker - Cirugía cardiáca o Marcapasos
Y N Racing Heart / or Palpitations - Taquicardia/ Palpitaciones
Y N Hernia Repair - Reparación de Hernia
Y N Swollen Feet or Ankles - Pies o tobillos inflamados
Y N Frequent Nose Bleeds - Sangrado de nariz frecuente
Y N Do you take insulin - Toma insulina?
Y N Thyroid Disease - Enfermedades de la Tiroides
Y N Do you take thyroid meds.? - Toma medicina para la tiroides?
Y N Steroid therapy including cortisone - Terapia esteroidal incluyendo cortizona

Y N Hormone Therapy - Terapia Hormonal

DENTAL HISTORY/HISTORIA DENTAL

Why have you come to the dentist today?/ Razón de su visita de hoy? _____

Are you REQUIRED antibiotics before treatment?/ Necesita tomar antibioticos antes de un tratamiento Y N

Are you currently in pain?/ Tiene dolor en este momento? Y N

Have you ever had a serious / difficult problem associated with previous dental work?/ Ha tenido alguno problema

o dificultad seria asociada con algún trabajo dental previo? Y N

Your current dental health is/ Su salud dental actual es: Good/Buena Fair/Regular Poor/Mala

Do you like your smile?/Le gusta su sonrisa? _____

Do your gums bleed?/ Le sangran las encillas _____

Have you ever had periodontal disease?/ Ha tenido alguna enfermedad periodontal Y N

How many times a week do you floss?/ Cuántas veces a la semana utiliza el hilo dental ____ A day do you brush?

/Cuantas veces al día se lava los dientes___ (type/tipo de cepillo: soft/suave medium/mediano hard/duro)

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent./Entiendo que la información que he dado es correcta en lo mejor de mi conocimiento. También entiendo que esta información será confidencial y que es mi responsabilidad avisar a esta oficina si hay algún cambio en mi estado de salud. Autorizo al personal dental de esta clínica de hacer cualquier servicio que sea necesario durante mi diagnóstico y que se me haga un tratamiento bajo mi consentimiento.

_____

Signature & Date/ Firma y Fecha

Patient Payment Responsibility Notice
Aviso de Responsabilidad de Pago

We accept Visa and Mastercard/ Aceptamos Visa y Mastercard

NOTICE/*AVISO*

IF YOU DON'T HAVE INSURANCE OR WE DON'T PARTICIPATE IN YOUR PLAN PAYMENT IN FULL IS EXPECTED AT TIME OF SERVICE/ ***SI USTED NO TIENE SEGURO O SI NO SOMOS PARTS DE SU PLAN, ESPERAMOS QUE PAGUE EL TOTAL EN EL MOMENTO DEL SERVICIO***

For Participating Insurance Plans/ Para los Planes de Seguro Participantes:

COPAYS/CO-PAGOS: Due At Time Of Service. ***Hechos al momento del servicio.***

ANNUAL DEDUCTIBLE/DEDUCIBLE ANUAL: Due at first non-diagnostic procedure. ***Pagado en el primer procedimiento que no sea diagnóstico.***

CO-INSURANCE: As a courtesy, we will file your health insurance. Once payment is received from your insurance, you will be billed for any co-insurance that is due. Payment in full is expected within 30 days, any balance that is carried over to the next billing cycle will incur a $25 monthly service fee each month until balance is paid in full./ ***Como una cortesía ingresaremos su seguro médico. En el momento en que el pago de su seguro sea recivido, se le enviara un recibo por cualquier pago de co-asegurado que este pendiente. Debe hacer el pago del total entre los 30 días siguientes, cualquier saldo que continúe en su siguiente ciclo de recibos incluirá un cobro de $25 de costo de servicio mensual, hasta que el saldo sea pagado totalmente.***

If your account is not paid in full within 30 days, any and all balances remaining on the account will be subject to a $25 monthly service charge. If your account is not paid in full within 60 days, it could be referred to a collection agency and additional expenses will be incurred to include 40% collection fee and court costs./***Si su cuenta no fuera cancelada por completo durante los 30 días, cualquier y todos los saldos restantes en l cuenta serán sujetos al cobro de $25 por servicios. Si su cuenta no es totalmente cancelada durante 60 días, será referida a una cobradora y se le cobrará adicinalmente un 40% por costos de cobros y corte.***

CREDIT (Capital One Healthcare Finance)/CREDITO. APPLICATIONS AND APPROVALS ARE COMPLETED ON THE SAME DAY WITHIN MINUTES./***APPLICACIONES Y APROVACIONES SE HACEN EL MISMO DIA, EN MINUTOS***

I have read, understand and agree to the Patient Payment Responsibilities listed above. I have been given a copy of this document./ ***He leído, entendido y estoy de acuerdo con las Responsabilidades de Pago del Paciente que han sido descritas arriba. Me han dado una copia.***

_____Date/***Fecha:***_____

Signature/***Firma***

Options Sheet for my records.

GARCES DENTAL GROUP
CANCELLATION POLICY/POLIZA DE CANCELACION

Dear Patient,/***Estimado paciente***

Please be aware that we realize your time is valuable. Please also realize that our office time is equally valuable. We make every effort to accommodate you and your schedule when making appointments for you./***Por favor, queremos que sepa que estamos concientes de que su tiempo es valioso. Asimismo que el tiempo de nuestra oficina también lo és. Hacemos todo el esfuerzo para agendarlo en nuestro horario al hacer una cita.***

Appointments, particularly on Saturdays are very limited. If you schedule an appointment it is an expected courtesy on your behalf to give our office 24 hours notice if you are unable to keep your scheduled appointment so that we can give the time allotted to another patient./ ***Si usted hace una cita y no puede venir, se espera de usted la cortesía de avisarnos 24 horas antes para que podamos agendar a otro paciente en este tiempo.***

To enforce this policy, we require a credit card number to be held on file in the event that you do not give our office 24 hours notice or do not keep your appointment./ ***Para reenforzar esta política requerimos un número de tarjeta de crédito para tenerlo como parte de su expediente caso que usted no avise a nuestra oficina 24 horas antes que no podrá venir o no mantiene su cita.***

Your card will be charged $100.00 for appointment broken or late cancellation between Monday through Friday./***Se le hará un cargo a su tarjeta de $100.00 por una inasistencia o una cancelación tardía.***

Thank you for your understanding and abiding by this policy./***Gracias por su comprensión y por respetar ésta política.***

The staff at GARCES DENTAL GROUP./ ***El equipo de GARCES DENTAL GROUP.***

_____ _____
Patient Signature/***Firma del Paciente*** Date/***Fecha***

_____ _____ _____
Credit card Number/# tarjeta de crédito (Visa or Master card) Exp. Date/ ***Fecha expiración***

_____
Phone Confirmation Date/***Fecha de confirmación telefónica***

Notice of Privacy Practices

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Facility Privacy Official by dialing the main medical office number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment and billing-related information. This notice applies to all of the records of your care generated by the medical office, whether made by medical office personnel, agents of the medical office, or your provider. Your health insurance, hospitals and other treatment providers may have different policies or notices regarding the use and disclosure of your health information.

Our Responsibilities:

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures:

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other medical office personnel who are involved in taking care of you at the medical office. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the medical office also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improve-ment team may use information in your health record to assess the care and out-
comes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may also combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and students for educational purposes. And we may combine health information we have with that of other medical offices to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- To contact you as part of fundraising efforts;
- To inform Funeral Directors consistent with applicable law;
- For population based activities relating to improving health or reducing healthcare costs; and
- For conducting training programs or reviewing competence of healthcare professionals.
- When disclosing information, primary appointment reminders and billing/ collections efforts, we may leave messages on your answering machine or voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include billing services, transcriptionists, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you, your insurance company or a third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our facility is participating.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State Specific Requirements: Many states have requirements for reporting, including population-based activities relating to improving health or reducing healthcare costs. Some states have separate privacy laws that may apply additional legal requirements. f the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to**:

- Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by the medical office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the medical office. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or healthcare operations where an authorization was not required.
- Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of your home. The facility will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the medical office and include the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the medical office by contacting the main number and asking for the Facility Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with the medical office, contact the Privacy Official. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in the doctor’s office or clinic.

HIPAA PATIENT CONSENT FORM/HIPAA CONSENTIMIENTO DEL PACIENTE

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office./ ***Nuestra notificación de Prácticas Privadas provee información acerca de como podemos utilizar y divulgar información médica protegida sobre usted. Esta notificación contiene una sección de Derechos de los Pacientes describiendo sus derechos por ley. Usted tiene el derecho de revisar nuestra notificación antes de firmar este consentimiento. Los términos de nuestra Notificación pueden cambiar. Si modificamos nuestra Notificación usted podrá recibir una copia revisada de ésta, contactándo a nuestra oficina.***

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement./***Usted tiene el derecho de pedir que restrinjamos el uso o divulgación de información médica protegida sobre usted para tratamiento, pago o operaciones médicas. No estamos obligados a estar de acuerdo con esta restricción, pero si lo aceptamos, haremos honor a nuestro acuerdo.***

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)./***Al firmar esta forma, usted nos da el consentimiento de usar y divulgar información médica sobre usted para tratamiento, pago y operaciones de cuidado médico. Usted tiene el derecho de revocar este consentimiento por escrito, firmado por usted. Sin embargo, al revocar este permiso no afectará ninguna divulgación que ya se halla hecho ya que dependía de su consentimiento previo***

The patient understands that/*El paciente entiende que:*

- Protected health information may be disclosed or used for treatment, payment, or health care operations/ ***Información médica protegida podrá ser divulgada o usada para tratamiento, pago o operaciones de cuidado médico.***
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice/ ***Esta práctica dental tiene una Notificación de Prácticas Privadas y que él paciente tiene la oportunidad de revisar ésta.***
- The Practice reserves the right to change the Notice of Privacy Practices/ ***Esta Práctica se reserva el derecho de cambiar la Notificación de Prácticas Privadas***
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions***/El paciente tiene el derecho de restringir el uso de la información pero ésta práctica no tiene porque estar de acuerdo con dichas restricciones.***
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease***/El paciente puede revocar este Consentimiento por escrito en cualquier momento y en el futuro cesará cualquier divulgación de dicha información.***
- The Practice may condition receipt of treatment upon the execution of this Consent./***ésta Práctica puede condicionar su tratamiento si usted***

This Consent was signed by/*Este consentimiento fue firmado por:* _____

Printed Name/***Nombre***

_____ _____

Signature/***Firma*** Date/***Fecha***

Relationship to Patient/ Relación con el paciente (if other than patient)/ (en caso no sea el paciente): _____

Witness/ Testigo: _____

Printed Name – Practice Representative/Nombre de Representante de la Práctica

_____ _____

Signature/Firma Date/Fecha

GARCES DENTAL GROUP
OFFICE POLICY I CONSENT FOR TREATMENT

* By signing this consent form, you authorize the dentist to take x-rays and perform the necessary dental procedures to improve your oral health, relieve you of pain I discomfort, detect cavities, abscesses, abnormalities, and to help prevent future dental problems./ ***Al firmar este consentimiento usted autoriza al Dentista a tomarle rayos X llevar a cabo los procedimientos dentales necesarios para mejorar su salud dental, aliviarlo de dolor o incomodidad, detectar caries, absesor, arnomalidades y ayudarle a prevenir futuros problemas dentales.***

* Since we are committed to providing the best dental care possible for patients, our fees reflect what is Usual & Customary for our area. However many insurance companies will arbitrarily set their own UC rates regardless of our area or state and pay accordingly to their schedules not our fees. Please not that the insurance companies do not guarantee payments or benefit percentages. Therefore, co-pays and benefits are estimations, thus, additional co-payments may be required from you after insurance payments are received/ ***Estamos comprometidos a brindar a nuestros pacientes el mejor cuidado dental posible, nuestros precios reflejan, los precios del mercado en nuestra área. Sin embargo, muchas compañias de seguros pondrán arbitrariamente su propia "lista de precios del mercado", sin tomar en cuenta el area ó estado y cubren según su agenda no según nuestros precios. Por favor tome en cuenta que las aseguradoras no garantizan pagos o porcentajes de beneficios. Así que, los co-pagos y beneficios son estimados, por ello, co-pagos adicionales podrán ser requeridos de usted después de que los pagos de la aseguradora se hayan recibido.***

*We request your payment or co-payment at the time these services are provided. Our fee for service policy helps alleviate outstanding accounts, finance charges and the high cost of billing, thus maintaining UC fees, thus, maintaining our fees, and providing the most advanced dental care. However, if financial obligations are not met, accounts will be subject to finance I late charges according to the laws and regulations of the state of Pennsylvania as of January 1, 1999./***Requerimos su pago o co-pago cuando se le lleven a cabo estos servicios. Nuestra poliza de pago por servicio ayuda a reducir cuentas pendientes, cargos de financiamiento y el alto costo de facturación, y así poder conservar precios del mercado, mantenerlos y proveer el cuidado dental más avanzado. Sin embargo, si los pagos no se cumplen, las cuentan serán sujetas a financiamiento y cobros por mora de acuerdo a las leyes y regulaciones del estado de Pennsylvania a partir del 1 de Enero de 1,999.***

*In addition, you, the patient or legal guardian (if the patient is a minor) are fully responsible for the account at Garces Dental Group regardless of dental insurance. Dental insurance is a contract between employees / insured party, their employer and insurance company Not Garces Dental Group**/ ***Adicionalmente, usted el paciente ó tutor legal (si el paciente es menor de edad) es totalmente responsable de la cuenta que tenga en Garces Dental Group independientemente de la aseguradora dental. El Seguro Dental es un contrato entre el empleado-asegurado, su patrono y la compañía de seguros no con Garces Dental Group.***

*I am aware that it is my responsibility to ask any questions, or relate any concerns I may have regarding the treatment, fees or my insurance (if applicable) prior to any procedure in order to make an educated decision regarding what is best for my dental health including no treatment at all. I agree that I am financially responsible for my treatment fees regardless of what my dental insurance covers. I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted and that this consent form does not encompass the entire discussion I had with the doctor and the staff./***Estoy conciente de es que es mi responsabilidad hacer preguntas sobre cualquier duda que tenga respecto a mi tratamiento, precios ó mi seguro (si aplica), antes de que inicien cualquier procedimiento para tomar una desición informada acerca de lo que sea mejor para mi salud denta;l aunque eso signifique no tener un tratamiento del todo. Estoy de acuerdo con que soy financieramente responsable por el costo de mi tratamiento, independientemente de lo que cubra mi seguro dental. Entiendo que no esta garantizado un resultado perfecto y que no puede ser garantizado tampoco; y que este forma no abarca la conversación que tuve con el (la) doctor (a) y el equipo de trabajo de la clínica.***

*I understand that the dental treatment may result in discomfort, soreness, bleeding, or swelling which may require several days for recovery. Other risk include injury to adjacent teeth, sensitivity, post

treatment infection requiring further treatment, temporomandibular joint difficulty, treatment failure, complications resulting from the use of dental instruments, and possible bruising (black and blue) of the face./ ***Entiendo que el tratamiento dental me puede causar incomodidad, dolor, sangrado o inflamación, lo que puede requerir varios días de recuperación. Otros riesgos incluyen lesión de dientes cercanos, sensitividad, infección después del tratamiento que requiera tratamiento extra, dificultad para mover la mandivula, tratamiento fallido, complicaciones por la utilización de instrumentos dentales, y posibles moretes en la cara.***

*Dental injections, medications, anesthetics and treatment may also cause unfavorable reactions, an altered sensation, taste, or feeling of the lips, chin, cheeks, and I or tongue which is usually temporary but may be permanent. I understand that there are also other less likely inherent and potential risks in any dental procedure and that antibiotics may inhibit the effectiveness of birth control pills./***Las inyecciones dentales, medicamentos, anestésicos y tratamiento también puede causar reacciones desfavorables, alteración de la sensación, gusto y en los labios, barbilla, mejillas y lengua; usualmente es temporal pero puede ser permanente. Entiendo que existen otros riesgos potenciales e ihnerentes menos probables en cualquier procedimiento dental; además entiendo que los antibióticos pueden inhibir la efectividad de las pildoras anticonceptivas.***

I acknowledge that I have read and understood this document and all questions have been answered completely. I consent to have treatment at Garces Dental Group./***Confirmo que he leído y entendido este documento y que todas mis preguntas han sido respondidas completamente. Doy consentimiento que me hagan tratameitno en Garces Dental Group.***

_____ _____

Signature of patient/parent-guardian (if minor) Date/***Fecha***
Firma del paciente/padre-tutor (de un menor)

_____ _____

Signature of office witness/***Firma de testigo*** Date/***Fecha***