**Yon Elejabarrieta, D.M.D**

We make every effort to provide you with an appointment that accommodates your schedule. Once the appointment is made, this time is reserved especially for you. If an appointment is can-celled without advanced notice it means that not only do you not get the treatment you need, but also another patient who could have taken that appointment to get treatment they need is unable to do so.

As a courtesy we call by telephone prior to the appointment to confirm, but please don't depend on this.

For professional cleaning appointments we send out appointment cards, three weeks in advance, as the confirmation of your appointment.

We reserve the right to charge for appointments cancelled without 24-business hour advanced notice. The fee for a broken appointment is $40.00. Long procedures, such as crown preparation, must be cancelled with 72-hour notice to avoid charge. The fee for an appointment of this type is $75.00. Exceptions to this can be determined on an individual basis according to the circumstances.

These charges are allowed by your insurance company but considered the patient's responsibility to pay.

If you have any questions about this, please don't hesitate to ask any member of our staff, they will be glad to answer your questions. We believe that good communication is the key to excellence in dental care.

Thank you for your cooperation.

Sincerely,

Dr. Yon, and Staff

I have read and understood the above information

Patient Signature: ______________________________ Date: ____________________

**10261 S.W. 72nd St, #C106 Miami, FL 33173 | (305) 271-3333 | artisticsmilesmiami.com**

ARTISTIC SMILES
FAMILY & COSMETIC DENTISTRY

YON ELEJABARRIETA, D.M.D

## PATIENT INFORMATION

Last Name ______________________ First Name ____________________ MI __________

Address ______________________________________________ City __________

State _______ Zip ______ Employer ______________ Occupation ______________

Social Sec No: ____________________ Driver Lic #: ______________________

Home Telephone: ________________________ Work Telephone: ______________

Email Address: ________________________________________________

Date of Birth: ______________ Sex: ☐M ☐F Martial Status: ☐M ☐S ☐D ☐W

Emergency Contact: ______________ Relationship: ______________ Phone: __________

## RESPONSIBLE PARTY

Relationship: ☐Self ☐Spouse ☐Child ☐Parent Date of Birth: __________

Last Name ______________________ First Name ____________________ MI __________

Address ______________________________________________ City __________

State ____________ Zip __________ Home Telephone: ______________________

Work Telephone: ________________ Social Sec No: ______________ Sex: ☐M ☐F

## INSURANCE INFORMATION

Insurance Company: ______________________ Address ______________________

Employee: ________________ SS# ______________ Phone #: ______________

Employer: ____________________________________ Group #: ______________

## DENTAL HISTORY

Please check the following conditions that apply to you:

☐Bad Breath ☐Grinding Teeth ☐Periodontal (GUM) Disease
☐Mouth Sores ☐Loose Teeth ☐Clicking/Popping Jaws
☐Bleeding Gums ☐Sensitive to Hot/Cold



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YON ELEJABARRIETA, D.M.D

# ARTISTIC SMILES
FAMILY & COSMETIC DENTISTRY

| | Yes | No | |
|---|---|---|---|
| Are you happy with your smile? | ☐ | ☐ | ________ |
| Do you avoid brushing any part of your mouth? | ☐ | ☐ | ________ |
| Do you smoke or chew tobacco products? | ☐ | ☐ | ________ |
| If you could make one change to your teeth, what would be it be? | ☐ | ☐ | ________ |

## MEDICAL HISTORY

**ALLERGIES:**

Have you ever had any of the following:

- ☐ Anemia
- ☐ High Blood Pressure
- ☐ Pace Maker
- ☐ Radiation Therapy
- ☐ Mitral Valve Prolapse
- ☐ Hepatitis/Liver Disease
- ☐ Chemical Dependency
- ☐ Other
- ☐ Artificial Joints
- ☐ Glaucoma
- ☐ Asthma
- ☐ Heart Murmur
- ☐ Kidney Disease
- ☐ Artificial Heart Valve
- ☐ Rheumatic Fever
- ☐ Cancer
- ☐ Respiratory Disease
- ☐ HIV Postivie/AIDS
- ☐ Tuberculosis Venereal Disease
- ☐ Circulatory Problems
- ☐ Heart Problems
- ☐ Diabetes
- ☐ Chemotherapy
- ☐ Epilepsy

**MEDICATIONS:** ____________________

____________________

## AUTHORIZATION:

I certify that I have read and understood the above information to the best of my knowledge and its use for my treatment, billing and processing for insurance benefits to which I am entitled. I understand that providing incorrect or inaccurate information can be dangerous to my health and I will not hold my dentist or any staff member responsible for errors or omissions that I have made.

Date: ____________________ Signature: ____________________

Doctors's Signature and Date: ____________ ____________ ____________

# Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________________________ , have received a copy of this office's Notice of Privacy Practices.

______________________________________________
Please Print Name

______________________________________________
Signature

______________________________________________
Date

## For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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