MUNDO DENTISTRY

Patient Information

First Name _____ Last Name _____
Address _____
City _____ State _____ Zip Code _____
Cell Phone _____ Secondary Phone _____
Date of Birth _____/_____/_____ Age _____
Social Security Number_____ Driver's License Number_____

Gender

☐ Sex ☐ Male ☐Female

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated

Email Address _____

*I would like to receive information via email

Insurance Information (Policy Holder Information)

First Name _____ Last Name _____
Address _____
City _____ State _____ Zip Code _____
Cell Phone _____ Secondary Phone _____
Date of Birth _____/_____/_____ Age _____
Insurance Name_____ Insurance Phone Number _____
Employer_____
Member ID_____ Group Number _____

Relationship to patient □ Self □ Mother □ Father □ Sibling □ Friend

How did you hear about our office?

□Radio - La Raza
□Radio – Latina
□Newspaper
□ Drive By
□ Internet / Google
□ Friend _____
□ Family Member
□ Other: _____

MUNDO DENTISTRY

Medical History (English)

Name of Patient _____ Date of Birth _____ Date Created _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now?	☐ Yes	☐ No	If yes:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes:
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes:
Do you take, or have you taken Phen-Fen or Redux?	☐ Yes	☐ No	If yes:
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	If yes:
Are you on a special diet?	☐ Yes	☐ No	If yes:
Do you use tobacco?	☐ Yes	☐ No	If yes:

Women, are you:

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ Other If yes:
Do you use controlled substances? ☐ Yes ☐ No If yes:

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatment ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Wounded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spell/Dizziness ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Couch ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
			Yellow Jaundice ☐ Yes ☐ No

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes:

Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Name of Patient _____ Date of Birth _____

MUNDO DENTISTRY

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Mundo Dentistry is authorized to release protected health information about the above named patient in the following manner and to the identified persons.

Entity to Receive Information Check each person/entity that you approve to receive information	Description of information to be released. Check each that can be given to person/entity on the left in the same section
☐ Voicemail	☐ Results of lab tests/x-ray ☐ Other
☐ Other person (s) (provide name and phone)	☐ Financial ☐ Medical
☐ Email communication – Provide email address* _____ * For text communication to occur, accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ * For text communication to occur, accept the disclosure below:	☐ Appointment reminders ☐ Other:

☐ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

☐ Photo of patient received by patient or legal guardian	☐ May be posted in office
☐ Photo taken by staff (Example: pre/post procedure)	☐ May be posted on website
☐ Other	☐ Other

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient of Personal Representative _____ Date of Birth _____

* Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct 2014

Mundo Dentistry Membership Plan/Dental Savers Plan

No Waiting Periods • No Deductibles • No Benefit Maximums • No Pre-Existing Condition Exclusions • No Claim Forms • Pay As You Go

Annual Benefits

- Unlimited Exams including Regular Checkups & any Emergency Exams
- 2 Regular or Periodontal Maintenance Cleanings
- Unlimited X-rays including Advanced CBCT/3D X-ray ($350 value)
- 2 Oral Cancer Screenings
- Up to 50% OFF All Other Treatment Needs including Crowns, Deep Cleanings, Extractions, Partials & Dentures, and Implants
- Up to 30% OFF Braces and Invisalign
- 5 YEAR WARRANTY On All Crowns, Bridges, Partials, Dentures, & Implants Limitations
- Plan benefits only available at Mundo Dentistry-this plan is not part of any other insurance or discount plan
- Services cannot be filed to dental insurance

How Much Does It Cost?

Annual Membership Fee is only $350 for adults and $150 for children under 18. Pay as you go until the annual fee is met. Example: if your new patient exam and cleaning cost $175 then you are half way to the annual fee.

Please Read and Sign Below:

This plan offers significant discounts on dental services. Member benefits may not be used with traditional dental insurance plans. For your convenience, the contract will renew at each anniversary period unless specifically canceled by member.

Signature _____ Date _____

Plan De Membresia Mundo Dentistry/Plan De Ahorro Dental

Sin Periodos de Espera • Sin Deducibles • Sin Limite de Beneficios
Sin Exclusiones de Condiciones Preexistentes • Sin Formas de Reclamo para el Seguro
Paga como Avance tu Tratameinto -

Beneficios Anuales

- Examenes ilimitados incluyendo consultas rutinarias y examenes de emergencia.
- 2 Limpiezas periodontal o regular
- Rayos-X ilimitados incluyendo el avanzadas imagenes 3D
- 2 examenes de deteccion/prevencion de cancer oral
- Hasta el 50% de descuento en tratamientos que necesites incluyendo coronas, limpiezas profundas, extracciones, implantes, parciales y dentaduras.
- Hasta el 30% de descuento en brackets e invisalign
- 5 AÑOS DE GARANTIA en todos las coronas, puentes, parciales dentaduras e implantes Limitaciones
- La membresia solo es valida en Mundo Dentistry – Este plan no forma parte de ninguna aseguradora o de ningun plan de descuento.
- Servicios aplicados con la membresia no pueden ser reclamados a las aseguradoras.
- No se puede combinar beneficios de miembros con descuentos de seguro.

Cual es el Costo por Membresia?

La membresia tiene un costo annual de solo $350 para adultos y solo $150 para niños menores de 18 años. Pague a como avance sus tratamientos hasta que complete la cuota anual. Por ejemplo: Si usted es un nuevo paciente y se hace un examen rutinario y una limpieza por un total de $175, ya habra completado la mitad de la cuota anual.

Por Favor Lea y Firme Abajo:

Este plan para miembros ofrece descuentos significantes en servicios dentales. Beneficios de miembros no se pueden adjuntar con planes de pago de las aseguranzas dentales. Para su comodidad, el contrato se renovara cada 12 meses a menos de que el paciente cancele personalmente la membresia.

Firma: _____ Fecha: _____