HANK BARRETO, DMD

FRANCINE MISCH-DIETSH, DDS

135 SAN LORENZO AVE. SUITE 640 CORAL GABLES, FL 33146

www.drhankbarreto.com ● 305.648.4998 ● drhankbarreto@gmail.com

Date:_____
Name:_____Spouse's Name:_____
Address:_____City:_____ State:_____ Zip:_____
Home Phone:_____ Business Phone:_____ Cel: _____
Email: _____
Date of Birth:_____ Sex:_____ Height: _____ Weight:_____
Occupation: _____ Social Security #: _____ Single _____ Married _____
In case of Emergency notify: _____ Phone: _____
Whom may we thank for referring you to us? _____

MEDICAL HEALTH

Name and address of physician: _____
Have you been under a physician's care during the past 2 years?_____ For? _____
Have you been treated in a hospital in the past 2 years? _____ For? _____
If female; are you taking hormones or birth control pills? _____ Are you pregnant or nursing? _____
Have you ever had a blood test for hepatitis? _____ Were you vaccinated? _____
Have you had cankers or cold sores on your lips, tongue, gums or body? _____
Do you require premedication before dental appointments? _____ Prescription: _____
Are you allergic to: Penicillin Codeine Sulfa Drugs Local Anesthetics Other: _____
What medications are you taking? Nerve Pills Pain Killers Muscle Relaxers Stimulants Blood Thinners Tranquilizers Insulin Meds for Osteoporosis Other(s) Please List:_____

HAVE YOU HAD OR DO YOU HAVE:

	YES	NO		YES	NO
Abnormal Blood Pressure	□	□	Slow Healing	□	□
AIDS	□	□	Frequent Headaches	□	□
Allergies	□	□	Hepatitis	□	□
Anemia	□	□	Herpes	□	□
Angina	□	□	Jaundice	□	□
Arthritis	□	□	Kidney disease	□	□
Artificial heart valves	□	□	Liver disease	□	□
Artificial joints	□	□	Organ transplant	□	□
Asthma	□	□	Pacemaker	□	□
Autism	□	□	Polio	□	□
Cancer	□	□	Prolonged bleeding	□	□
Chemotherapy	□	□	Prolonged cough	□	□
Congenital Heart Lesions	□	□	Psychiatric treatment	□	□
Diabetes	□	□	Radiation Therapy	□	□
Drug Dependency	□	□	Rheumatic Fever	□	□
Epilepsy	□	□	Sexually transmitted disease	□	□
Fainting	□	□	Sickle Cell Anemia	□	□
Glaucoma	□	□	Sinus problem	□	□
Heart Disease	□	□	Stroke	□	□
Heart Murmur/Mitral Valve	□	□	Thyroid disease	□	□
Easily Exhausted or fatigued	□	□	Tuberculosis	□	□
			Ulcers	□	□

Have you any disease, condition, or problem not previously listed?_____

When was your last dental visit?_____

How often did you see your dentist? _____

Are you having any dental problems that require immediate attention? _____

Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____ Chewing _____

How often do your brush your teeth? _____ Floss?_____ Water Jet? _____

Do your gums bleed?_____

Do your gums ever feel tender or swollen? _____

Have you had periodontal treatment? _____ When? _____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Click or pop? _____

Can you chew on both sides of your mouth? _____ Comfortably? _____

Do you search for a place to close your teeth? _____

Do you have frequent headaches? _____ Earaches? _____

Do you have tightness, tiredness, in the head, neck or throat? _____

Have you ever had orthodontic treatment (braces)? _____ When? _____

Do you lose fillings or break fillings? _____

Do you usually have many cavities? _____

Do you have any loose teeth? _____ Cracked or broken teeth? _____

Do you have any noticeable wear on your teeth? _____Food Trap? _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how? Fixed bridge _____ Removable partial _____ Full Denture _____ Dental Implants _____

Are you comfortable with the replacement? _____ Please describe _____

How do you feel about the appearance of your smile? _____

Have you ever had any cosmetic dentistry done to improve your appearance? _____

If yes, are you pleased with the result? _____ Please comment _____

Have you ever had an unpleasant dental experience? _____

Do you have bitter or metallic taste in your mouth? _____

Please add anything you feel is important _____

• I understand the above information and guarantee this form was completed correctly to the best of my knowledge and u is my responsibility to inform this office of any changes to the information I have provided.

Patients Signature: _____

Doctors Signature:_____

- I authorize that the photographs, slides, and/or videos will be used as a record of my care, and understand may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines, social media). I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.
- I understand that I will be responsible for any fees incurred by Enrique Barreto DMD PA and or Mischex, LLC to collect fees due from me in the event of a lawsuit, including collection agency fees, attorney fees, and court costs.
- Dr. Barreto & Dr. Misch appreciate online reviews and video reviews. I acknowledge that my online reviews of Dr. Barreto and or Dr. Misch and their office are the sole property of Enrique Barreto DMD PA
- Do we have permission to:

_____
Signature

_____
Signature

_____
Signature

Leave a message on your voice mail @ home	YES	NO
Leave a message on your Cell Phone Voice Mail	YES	NO
Send a text message to your Cell phone	YES	NO
Discuss your medical condition with any member in your household	YES	NO

If yes whom: _____
Relationship:_____

Patients Signature_____

Doctors Signature_____

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Patient Financial Policy

We are committed to providing excellent dental care and the finest service possible for all of our patients. Good communication concerning dental problems, treatment procedures, and fees in one of our most important goals. In order to minimize expenses, we request payment for services at the time they are rendered.

Payment Options:

A. Master Card, Visa, American Express Care Credit and Personal Checks are accepted.

Interest Charges: 12% APR interest will be charged to balances over 90 days.

NSF Checks: A fee of $35.00 will be charged to all accounts with checks returned for any reason.

Collection fees: If a collection action needs to be taken, you would be responsible for all the charges.

Broken Appointments: Our policy is to charge any patient for a broken appointment. It is required that the patient speaks with someone directly within one working day before the day of their appointment. If the appointment is 90 minutes or longer it is required that the patient speaks with someone directly within two working days before the day of their appointment. When you fail to notify us in this manner, the charges will be $175.00 for every half an hour scheduled with Dr. Barreto and $85.00 an hour for hygiene appointments.

Insurance: We are a fee for service office, and we do not have a contract with your insurance (payment is due upon services rendered). As a courtesy we will submit claims to the dental insurance company for reimbursement to the patient. Any and all insurance related questions and concerns should be addressed to the insurance company directly.

Signature:_____Date: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ana M. Reyna

Tel.: (305) 648-4998 Fax:(305) 648-4993 E-mail: drha nkbarreto@yahoo.co m

Address: 135 San Lorenzo Ave. Suite 640, Cora l Gables, FL 33146

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I_____, have had full opportunity to receive, read and understand the contents of this Consent form and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations. I understand that this organization has the right to change its Notice of Privacy Practices from time to time
and that I may contact this organization a t any time a t the address above to obtain a current copy of the Notice of Privacy Practices.

Signature:_____ Date:_____

If this consent is signed by a legal guardian on behalf of the patient, complete the following:

Legal Guardian's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare op era tions.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice o f Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date: _____

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Adjunctive Oral Cancer Screening Acceptance Form

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors.**

Oral Cancer Risk profile

Increased risk

- **Patients age 40 and older (95% of all cases)**
- **18-39 years of age combined with any of the following:**
  - **Tobacco use**
  - **Chronic alcohol consumption**
  - **Oral HPV infection**

Highest risk

- **Patients age 65 and older with lifestyle risk factors**
- **Patients with history of oral cancer**
- ***25% of oral cancers occur in people who don't smoke and have no other risk factors.***

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life.

ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. The fee for this enhanced examination is ***$65.00.***

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have the ViziLite Plus exam at this time.

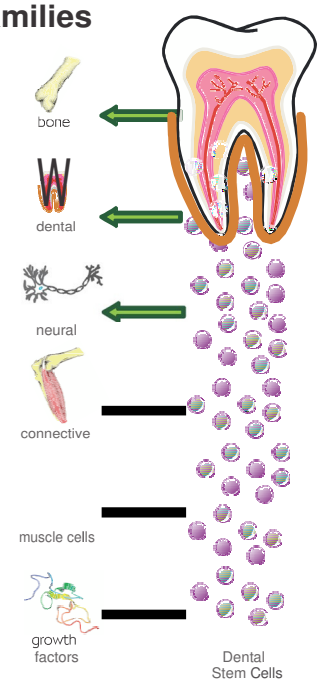
Print name: _____

Signature: _____ Date: _____

Did you know there are stem cells in teeth?

Store-A-Tooth™ Stem Cells for Life

Similar to banking stem cells from a baby's umbilical cord blood, many families are now choosing to save stem cells that are found in the pulp of teeth .



Research is promis ing for a variety of potential future therapies. Some examples include the development of treatments for type 1 diabetes, spinal cord injury, heart attack, stroke, liver disease, MS, Parkinson's, Alzheimer's and many more.

Since there is a limited amount of time in which these cells can be preserved, you would need to make the decision to store them prior to your procedure.

For this reason, prior to their extraction, all of our eligible patients are offered the option to receive a call from a clinical specialist at Store-A-Tooth who can provide an overview of the potential value of these cells.

There is *an additional* cost *to enroll in Store-A-Tooth 's private dental* stem *cell banking service. However, there* is *no* cost *to speak with a Clinical Specialist, nor* does *filling out this form obligate you to enroll in this optional service .*

☐ **Yes! Please call me so that I may learn more about stem cells before my/my child's extraction.**
If the extraction will take place within the next **48 hours** please call us directly at (877) 867-5753.

___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number

Extraction Appointment Date *(if available)*

Parent/Guardian Name and Contact Information

(If you are under 18, prefer we contact a parent, or are requesting information for your child.)

☐ **No, thank you. If interested, I will visit www.store-a-tooth.com to learn more.**

Optional: *Provide your email address if you prefer to receive an email with general information.*

*Patient Name

*Signature

*Date

FOR OFFICE USE ONLY: Please fax this form to Store-A-Tooth on the same day it was completed. **FAX# (877) 608-5636**

Patient Advocate

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RECORDS RELEASE REQUEST

DATE: _____

PATIENT: _____

D.O.B:_____

ADDRESS: _____

CITY: _____ **STATE:** _____**ZIP:** _____

Previous Dentist Name:
Tel:

I authorize the release of medical records including CT Scan or copies of such, and request that they be transferred to:

(Email is preferred)
drhankbarreto@gmail.com

Or by mail to:
Hank Barreto, DMD
135 San Lorenzo Ave.
Suite 640
Coral Gables, FL 33146

_____ _____
Print name of patient Signature (patient, parent or guardian)