First Name: ___________________ Middle Initial: __________ Last Name: _____________________________

Preferred Name: ____

SSN: ____/____/_____ DOB: ____/____/_____ Sex: M / F Marital: S/M/D/W

Mailing Address: ____

City: _____________________________________ State: ________ Zip code: ____________________________

Home Phone: ________________ Work Phone: __________________ Cell Phone: _________________________

Emergency Contact: ______________________________ Phone Number: _______________________________

Email Address: ____

How did you hear about our office? ____

Primary Dental Insurance Coverage

Subscriber Name: _________________________ Relation to Patient: __________________________________

SSN: ____/____/_____ DOB: ____/____/____ Employer: _______________________________________

Plan Name: __________________________________ Group Number: _________________________________

Insurance Company: ____

Insurance Company Phone Number: __________________________________

Claims Mailing Address: ____

City: ________________________ State: _______________ Zip Code: ______________

Assignment & Release

I hereby authorize my insurance benefits to be dispersed to my insurance plans subscriber, myself or spouse. I am financially responsible for any balances due and authorize the dentist to submit dental claims on my behalf as well as any information needed to process this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy. I consent to the taking of photographs and x-rays before, during and after treatment, and to use the same by the doctor in scientific papers, before and after photos, or demonstrations. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature: ____ **Date**: ______________________

Medical History

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

Physicians Name: ____________________________________ Date of last visit: ________________________

Please mark "Yes" to indicate if you currently have or have had any of the following:

Condition		Condition		Condition	
Acid Reflux	◯ YES	Drug Use	◯ YES	Low Blood Pressure	◯ YES
AIDS/HIV	◯ YES	Drug/Alcohol Rehab	◯ YES	Lung Disease	◯ YES
Alcohol Use	◯ YES	Eating Disorder	◯ YES	Mitral Valve Prolapse	◯ YES
Alzheimer's/Dementia	◯ YES	Emphysema	◯ YES	Neck Problems	◯ YES
Anemia	◯ YES	Epilepsy/Seizures	◯ YES	Nursing	◯ YES
Angina/Chest Pains	◯ YES	Excessive Thirst	◯ YES	Osteoporosis	◯ YES
Arthritis/Rheumatism	◯ YES	Fainting/Dizzy Spells	◯ YES	Parathyroid Disease	◯ YES
Artificial Heart Valve	◯ YES	Gag Reflex (Severe)	◯ YES	Pregnant or Trying	◯ YES
Artificial Joint	◯ YES	Glaucoma	◯ YES	Psychiatric Care	◯ YES
Asthma	◯ YES	Hearing Problems	◯ YES	Radiation Treatment	◯ YES
Auto Immune Disorder	◯ YES	Heart Attack/Failure	◯ YES	Rapid Weight Loss	◯ YES
Blood Disease	◯ YES	Heart Disease	◯ YES	Renal Dialysis	◯ YES
Blood Transfusion	◯ YES	Heart Murmur	◯ YES	Rheumatic Fever	◯ YES
Breathing Problems	◯ YES	Heart Pacemaker	◯ YES	Shingles	◯ YES
Bruise Easily	◯ YES	Hemophilia	◯ YES	Sickle Cell Disease	◯ YES
Cancer	◯ YES	Hepatitis A	◯ YES	Spina Bifida	◯ YES
Chemotherapy	◯ YES	Hepatitis B or C	◯ YES	STD/STI	◯ YES
Circulatory Problems	◯ YES	High Blood Pressure	◯ YES	Stomach/Intestinal Disease	◯ YES
Cirrhosis	◯ YES	High Cholesterol	◯ YES	Stroke	◯ YES
Cold Sores/Herpes	◯ YES	Hypoglycemia	◯ YES	Swelling of Limbs	◯ YES
Congenital Heart Disorder	◯ YES	Irregular Heartbeat	◯ YES	Thyroid Disease	◯ YES
Cortisone Medicine	◯ YES	Kidney Problems	◯ YES	Tonsillitis	◯ YES
Cough (Persistent)	◯ YES	Leukemia	◯ YES	Tuberculosis	◯ YES
Diabetes	◯ YES	Liver Disease	◯ YES	Tumors/Growths	◯ YES

Any serious illness not listed above? ◯ YES ◯ NO If yes, please explain: ________________________________

MEDICATIONS (please list)	

ALLERGIES					
Acrylics	◯ YES	Codeine	◯ YES	Penicillin	◯ YES
Anesthetics	◯ YES	Erythromycin	◯ YES	Red/Blue Dye	◯ YES
Aspirin	◯ YES	Fluoride	◯ YES	Sulfa Drugs	◯ YES
Chlorhexidine	◯ YES	Latex	◯ YES	Tetracycline	◯ YES
Clindamycin	◯ YES	Metals	◯ YES	Other:	◯ YES

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.

Signature of Patient or guardian: ____________________________________ **Date**: ______________

Dental History

Current Dental Conditions or Concerns (please check all that apply).

Dental Anxiety/Fear	◯ YES	Jaw Pain /Headaches	◯ YES	Tooth is Broken	◯ YES
Dental Cleaning (need)	◯ YES	Metal Fillings	◯ YES	Tooth is Cracked	◯ YES
Difficulty Getting Numb	◯ YES	Oral Cancer Concern	◯ YES	Tooth is Loose	◯ YES
Dry Mouth/Mouth Breathing	◯ YES	Periodontal Disease	◯ YES	Tooth is Missing	◯ YES
Gum Disease	◯ YES	Tobacco Use / Vaping	◯ YES	Tooth Pain	◯ YES
Gum Pain	◯ YES	Teeth are Crooked	◯ YES	Tooth Sensitivity	◯ YES
Gums Bleed	◯ YES	Teeth Grinding	◯ YES	Wisdom Teeth	◯ YES

I am interested in the following (please check all that apply).

Braces or Invisalign	◯ YES	Dentures	◯ YES	Sedation Dentistry	◯ YES
Cavity Prevention Program	◯ YES	Fluoride Treatment	◯ YES	Sleep Apnea Device	◯ YES
Dental Crown or Bridge	◯ YES	Nitrous (laughing gas)	◯ YES	Smile Makeover/Veneers	◯ YES
Dental Implants	◯ YES	Payment Plan (care credit)	◯ YES	Teeth Whitening	◯ YES

Do you require a premedication or antibiotic for dental treatment? ◯ YES

Would you like a blanket for your dental visits? ◯ YES

Do you have a difficult time with dental x-rays? ◯ YES

Do you have any special requests when getting your teeth cleaned? ◯ YES

Please specify: ____

Please list any additional dental information or concerns not listed above ___________________

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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.

Signature of Patient or guardian: ____________________________________ **Date**: ______________

<u>Appointment Policy</u>

From the first time we meet our dental guests it is our goal to establish an open line of communication. With clear communication and a mutual understanding, we can work together in achieving a lifetime of dental health.

We understand that your time is very valuable, and we work very hard to ensure that your time with us is spent efficiently and effectively.

When we schedule a dental visit for you, this time is yours. It belongs to you because you deserve our undivided attention. Just as your time is precious to you, our time is also valuable to us.

When cancellation occurs without proper notice someone else in need has lost the opportunity to have much needed access to dental care.

Due to the importance of our appointments, we require a 24-hour cancellation notice. There will be a fee of $50.00 if we do not receive a minimum of 24 hours' notice before your appointment. We thank you in advanced for your consideration.

I have read and understand the appointment policy.

Print Name: ____

Signature: ____

Date: ____________________________

Financial Policy

1. PAYMENT is expected in full at the time of your visit. If you have dental insurance, your insurance company will send you a check in the mail. We will accept cash, check, or credit card. We do offer payment plans through Care Credit and Lending Club.

2. INSURANCE We are not participating providers with all insurance plans. We will file all of these insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge.

We will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

3. LATE CHARGES of 15% annually will be applied to all patient balances 90 days old or greater.

4. RETURNED CHECKS will incur a $35.00 service charge. You will be asked to bring cash, certified funds, or money order to cover the amount of the check plus the $35 service charge to pay the balance before receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $35 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Hays County.

5. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $50 missed appointment fee.

6**. COLLECTION FEES:** I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest, and fines. I understand that these additional fees will be my responsibility to pay in full.

I have read and understood the practice's financial policy and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice from time to time.

Print Patient's Name: ____

Signature of Patient (or Guarantor, if applicable) ______________________________________

Date: __________________________

<u>Acknowledgment of Receipt of Notice of Privacy Practices</u>

You May Refuse to Sign This Acknowledgment

I, ___________________________________ have received a copy of this office's

Notice of Privacy Practices.

Print Name: ___________________________________

Signature: ____________________________________

Date: __________________________

For Office Use Only

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

___ Individual refused to sign

___Communication barriers prohibited obtaining the acknowledgment

___An emergency prevented us from obtaining acknowledgment

___Other (Please Specify)

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