FORT WORTH
# DENTAL

Advanced Dentistry ■ Friendly People ■ Modern Atmosphere

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## Patient Information *(Confidential)*

Date:_____

For medical and insurance purposes, we require the following information. Please complete fully, sign and provide us your Insurance Card, Driver's License and/or Pictured ID. Thank you.

Name: DOB:

*Last* *First* *Middle* *Nick Name*

Address: City: State: Zip:

Drivers License #: SS #:

Gender: ❍ M ❍ F Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Other:

The best way to contact you

Cell Phone: Home Phone: Email:

Employer: Occupation:

Address: City: State: Zip:

Work Phone: Ext:

Person to Contact in Case of Emergency

Name: Relationship: Phone:

Name of Pharmacy: Phone:

How did you find out about us? *(Please √ what applies)*

❍ Newspaper ❍ Phonebook ❍ Insurance List ❍ Drive by ❍ Fastbraces

❍ Facebook ❍ Website ❍ Radio ❍ Friend/Current Patient ❍ Other

Name of person responsible for this account: Relationship:

Address: Phone:

Drivers License #: SS #: DOB:

Employer: Work Phone: Ext:

OFFICE CANCELLATION AND FINANCIAL POLICIES *(Please initial each statement after reading.)*

_____As a courtesy to you we may accept assignment of insurance after verification of your coverage. We must emphasize that, as your dental provider, our relationship is with you and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.

_____Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for all services not covered by your insurance company.

_____Payment is due upon receipt of billing statement. Patient balance not paid, in full within 30 days statement issue date are deemed past due. Past due accounts may be subject to late fees, monthly finance charges and may be referred to a professional collection activity. If this action occurs, you will no longer be able to receive services from any dental providers at Fort Worth Dental.

_____All returned checks are subject to a $50 return check fee.

_____All appointments that are not cancelled 24hours prior to appointment time will be subject to a $50 "No Show" Fee.

_____All payments, including insurance co-payments and deductibles are due and collected in full at the time of service.

_____You must provide your current billing address, all available telephone numbers and any other important contact information.

_____It is your responsibility to supply the office with any information changes (insurance, name, email, address, and phone numbers).

I have read and understand this Financial Policy.

Signature of Responsible Party Date

## Medical History

Patient Name: _____

Physician's Name: Phone:

Address: City: State: Zip:

Date of Last Physical Exam:

ARE YOU TAKING ANY MEDICATION, PRESCRIPTION OR OVER THE COUNTER? ❍ Yes ❍ No

IF YES, PLEASE LIST EACH ONE:

PLEASE LIST ANY HEALTH RELATED OR HERBAL SUBSTANCES THAT YOU ARE PRESENTLY TAKING:

ARE YOU TAKING ASPRIN? ❍ Yes ❍ No If Yes, why?

ARE YOU TAKING ANY TYPE OF BLOOD THINNER? ❍ Yes ❍ No

DO YOU REQUIRE AN ANTIBIOTIC PRE-MEDICATION FOR DENTAL APPOINMENTS? ❍ Yes ❍ No

Are you ALLERGIC to or have you had REACTIONS to any of the following? ❍ NONE

❍ Penicillin ❍ Tetracycline ❍ Latex ❍ Aspirin ❍ Dental Anesthetics

❍ Erythromycin ❍ Codeine ❍ Other

Do you have any of the following? *(Please √ any that may apply to you)* ❍ NONE

| | | | |
|---|---|---|---|
| ❍ High Blood Pressure | ❍ Asthma | ❍ Tumor | ❍ Rheumatic Fever |
| ❍ Dizziness | ❍ Allergies | ❍ Respiratory Problems | ❍ Sinus Problems |
| ❍ Lung Problems | ❍ Blood Disorder | ❍ Kidney Problems | ❍ Pacemaker |
| ❍ Fainting | ❍ Cancer | ❍ Anemia Excessive Bleeding | ❍ Heart Disease |
| ❍ Liver Disease | ❍ Leukemia | ❍ Arthritis or Rheumatism | ❍ Chemotherapy |
| ❍ Tuberculosis | ❍ Stomach Problems | ❍ Epilepsy/Seizures | ❍ Low Blood Pressure |
| ❍ Artificial Prosthesis | ❍ Liver Problems | ❍ Glaucoma | ❍ Radiation Treatment |
| ❍ Venereal Disease | ❍ Stroke | ❍ Thyroid Problems | ❍ Artificial Joint Replacement |

Artificial Heart Valve Heart Murmur *(including MVP)* ❍ Yes ❍ No

HIV/AIDS when were you diagnosed?

Hepatitis when were you diagnosed? What type?

Diabetes when were you diagnosed? What type?

Do you smoke? ❍ Yes ❍ No Use Snuff? ❍ Yes ❍ No Use any other form of tobacco? ❍ Yes ❍ No

Do you feel tired during the day? ❍ Yes ❍ No Have you had a sleep test? ❍ Yes ❍ No

Have you been told you snore? ❍ Yes ❍ No Do you wear a CPAP? ❍ Yes ❍ No

Have you ever had a major surgery or illness? ❍ Yes ❍ No

If yes, please explain:

Hospitalization? ❍ Yes ❍ No

If yes, please explain:

WOMEN ONLY: Are you pregnant or suspect that you may be? ❍ Yes ❍ No

If yes, week# Due Date:

Do you use any birth control medications? ❍ Yes ❍ No

I CERTIFY THAT ALL OF THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.

Signature of Patient or Legal Guardian Date

# Dental History

Patient Name: _____

Reason for today's visit:

Date of your last dental Exam: Cleaning: X-rays:

Name of your previous Dentist:

Location:

Do you have any of the following? *(Please √ any that may apply to you)*

❍ Pain ❍ Gums Bleed ❍ Sensitivity to what? ❍ Hot ❍ Cold ❍ Pressure ❍ Other

❍ Clench/Grind ❍ Jaw Problems (TMJ/TMD) ❍ Stain ❍ Bad Breath ❍ NONE

What is your regular hygiene care? *(Example: brush 2 x day)*

Brush: x Floss: x Dental Visit: x

What type of toothbrush do you use? ❍ SOFT ❍ MEDIUM ❍ HARD ❍ ELECTRIC

| | | |
|---|---|---|
| Do wish your teeth were whiter? | ❍ Yes | ❍ No |
| Have you ever been diagnosed with periodontal disease (gum disease)? | ❍ Yes | ❍ No |
| Other Dental Concerns: | | |
| Have you ever had an unpleasant Dental experience? | ❍ Yes | ❍ No |
| If yes, please explain: | | |
| Have you ever had Braces? | ❍ Yes | ❍ No |
| Would you be interested in getting Braces? | ❍ Yes | ❍ No |
| Are any of your teeth loose, shifted or chipped? | ❍ Yes | ❍ No |
| Do you dislike the shape of your teeth? | ❍ Yes | ❍ No |
| Do you get food caught in your teeth? | ❍ Yes | ❍ No |
| Have you lost teeth or have any teeth been removed? | ❍ Yes | ❍ No |
| Do you get nervous? | ❍ Yes | ❍ No |
| Would you be interested in SEDATION OPTIONS? | ❍ Yes | ❍ No |
| Are you happy with the way your smile looks? | ❍ Yes | ❍ No |
| If no, what would you like to change? | | |

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I give my consent for the use of email notifications. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or dependents.

Signature of Patient or Legal Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____

Please Print Patients Name Signature of Patient or Legal Guardian

Medical information released is only with your permission and will not be given unless that person's name is listed:

Release to: _____ Relationship:_____
Date of Birth:_____

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FOR OFFICE USE ONLY
____ Individual refused to sign
____Communication barriers prohibited obtaining the acknowledgement
____An Emergency situation prevented us from obtaining acknowledgement
____Other:_____