

PATIENT INFORMATION

Name: _____ Hm phone: _____ Wk phone: _____

Cell phone: _____ Email address: _____

Home address: _____ City: _____ Zip code: _____

Employer: _____

Address of employer: _____ Phone #: _____

Your social security # _____ Date of birth: _____

Driver's license # _____ Who is responsible for your bill? _____

I will be paying any charges for today by: cash _____ check _____ credit card _____

Spouse's name: _____ Spouse's phone: _____

Nearest relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Landlord: _____

Whom may we contact in case of an emergency? _____ Phone: _____

Whom may we thank for referring you? _____ Phone: _____

Insurance

Name of insured: _____ SS# / ID# of insured: _____

DOB of insured: _____

Insurance plan name and phone # _____

Insured relation to patient: _____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I understand that all fee estimates for any dental care I may need can only be extended for a period of six months from the date of the patient examination. I certify that the above information is true and correct to the best of my knowledge. I will notify you, should there be any changes in the above information.

Signature

Date

Parent (if minor)

Date

HEALTH HISTORY

How long since **last** dental visit: _____ Reason for today's visit: _____

Have you ever had any of the following medical conditions? Please check all that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Growths | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> I have no medical conditions |
| <input type="checkbox"/> Allergies (seasonal) | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Allergies (to meds) | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Venereal Disease | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tobacco Use | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy | | |
| <input type="checkbox"/> Glaucoma | Due Date _____ | _____ | |

1. Are you taking any drugs or medications? ____Yes ____No
If yes, please explain: _____

2. Are you **allergic** to any drugs? ____Yes ____No
If yes, please explain: _____

3. Have you ever had any complications following dental treatment: ____Yes ____No
If yes, please explain: _____

4. Have you been admitted to a hospital or needed emergency care during the past two years? ____Yes ____No
If yes, please explain: _____

5. Are you now under the care of a physician? ____Yes ____No
If yes, please explain: _____

Name of physician: _____ Phone: _____

6. Do you have any health problems that need further clarification? ____Yes ____No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient/guardian

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the *Health Insurance Portability & Accountability Act of 1996 ("HIPAA")*, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❖ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- ❖ Obtain payment from third-party payers.
- ❖ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I give permission to discuss my dental condition and/or finances with the following person(s):

I give permission for the office to leave messages on my voicemail and/or email. Yes or No

Patient Name: _____

Your relationship to the patient: _____

Signature of Patient/Guardian: _____

Date: _____

INSURANCE PAYMENT INFORMATION

Patient: _____

Insurance carrier: _____

Employer providing insurance: _____

Subscriber ID# / SS#: _____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to: Frisco Dental Associates, 8715 Lebanon Road, Suite 300, Frisco, TX 75034.

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Frisco Dental Associates
8715 Lebanon Rd. Suite 300
Frisco, TX 75034

for the professional or dental expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

- ❖ I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
- ❖ I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ❖ If my policy prohibits direct payment to the doctor, I authorize the doctor to deposit insurance checks received on my account when made out to me.

Dated at Frisco Dental Associates this _____ day of _____, 20_____

Signature of policyholder

Witness

Signature of claimant, if other than policyholder