WELCOME TO OUR OFFICE

Date:_____.

Thanks for choosing our office.

To be able to serve you better we need the following information. (Please Print) This information is strictly confidential.

Patient's Name:_____.
First Last Initial

Social Security:_____. Sex: M F Date of Birth:_____.

Responsible Party Information:

Name:_____.
First Last Initial

Address:_____.

City:_____State:_____. Zip Code:_____.

Home Phone Number:_____. Cell:_____.Work:_____.

Driver's License Number:_____. Email:_____.

Employer:_____. Occupation:_____. # of year's employed_____.

Date of Birth:_____. Relationship to Patient:_____.

Reason for today's visit?_____.

Whom may we thank for referring you to our office?_____.

Is the patient apprehensive to dental treatment? YES NO

Are any teeth sensitive to HOT or COLD? YES NO

Do your gums bleed or feel irritated? YES NO

Is the patient seeing a physician? YES NO If so, what is the patient being treated for?_____.

Name and address of physician:_____.

What MEDICATIONS is the patient currently taking?_____.

Are you currently PREGNANT? YES NO How many month's?_____.

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAD OR HAVE AT THE PRESENT TIME:

-Heart Disease	-Heart Pacemaker	-Ulcers	-Arthritis	-High Blood Pressure
-Diabetes	-Tuberculosis	-Sickle Cell Disease	-Rheumatic Fever	-Anemia
-Hay Fever	-Pain in Jaw	-Heart Murmur	-Kidney Problems	-Nervousness
-HIV+	-Venereal Disease	-Epilepsy or Seizure	-Thyroid Disease	-Hepatitis

Other:_____.

CIRCLE ANY OF THE FOLLOWING MEDICATION YOU ARE ALLERGIC TO:

-Local Anesthetic	-Sulfa Drugs
-Codeine	-Penicillin
-Aspirin	-Latex

Other:_____.

To the best of my knowledge, all of the following answers are correct. I will notify office if there are any changes to my health or changes in medication consumption at next appointment.

Signature:_____. Date:_____.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INOFORMATION. PLEASE READ IT AND REVIEW IT CAREFULLY.

By law we are required to provide you with our Notice of Privacy Practices (NNP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

The right to inspect a copy of your information;
The right to request corrections to your information;
The right to request your information is restricted;
The right to request confidential communications;
The right to report of disclosures of your information; and
The right to a paper copay of this notice.

We want to assure you that your medical protected health information is secure with us. The Notice of Privacy Practices contains information about how we ensure that your information remains private.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have reviewed this practice's Notice of Privacy Practices. I further understand that the practice will offer me updated to this notice. Should it be modified or changed in any way I will receive a copy.

_____.
Print name of Patient

_____.
Signature of Patient/Parent/Legal Guardian

_____.
Date

1215 W. Pioneer Parkway Suite 250

Grand Prairie, TX 75051

We are happy to file your insurance claims for you, and will help you with coordination of benefits. In order for us to bill your insurance company you will need to provide us with a copy of an insurance card or billing address for them. As a courtesy to you, we verify your dental benefits. However, it is your responsibility to verify your own benefits with your insurance company, as you are ultimately responsible for your bill.

If you have a percentage co-insurance payment, please be aware that the amount you are paying at each visit is **only an estimate.** We do not know the exact amount of your co-insurance payment until we receive payment from your insurance company. You may receive an additional bill from us after we have received payment from your insurance company.

You may become responsible for your bill if:

- Claim is returned based on the information you or your insurance company provided us
- Our office provides composite fillings (white) and some insurance companies down grade to amalgam fillings (silver) rates. You will be responsible for the difference in cost.
- You are not sure which insurance company has primary responsibility for payment.
- Your eligibility or pre-authorization for services has expired and you elect to continue treatment.
- Your insurance company determines that in their opinion treatment was not necessary.
- An authorization is revoked by insurance.
- If your insurance policy has waiting periods under your plan for basic or major treatment procedures.

Patient Name:_____ **Date:**_____

Patient / Legal Guardian Signature:_____