

PATIENT INFORMATION

Name _____

Birth Date _____

Address _____

Home phone _____

City _____ State _____ Zip _____

Minor Single Married

Patient or parent's employer _____

Divorced Widowed Separated

Business Address _____

City _____ State _____ Zip _____

Work phone _____

If pt is a student, name of school _____

Cell phone _____

City _____ State _____ Zip _____

Other phone _____

Whom may we thank for referring you? _____

Email _____

RESPONSIBLE PARTY

Person responsible for this account _____

Relationship to patient _____

Address _____

Home phone _____

City _____ State _____ Zip _____

Work phone _____

Employer _____

Cell phone _____

Address _____

Birth Date _____

City _____ State _____ Zip _____

Social Security # _____

INSURANCE INFORMATION

Same as above

Group # _____

Name of Insured _____

Insurance Phone # _____

Insurance Company _____

Relationship to patient _____

Address _____

Birth Date _____

City _____ State _____ Zip _____

Social Security # _____

MEDICAL HISTORY

Are you under the care of a physician?	Yes / No	Physician's Name _____
Have you been hospitalized in the last five years?	Yes / No	Physician's # _____
Are you taking medications? Including over the counter and prescription.	Yes / No	Date of last exam _____
Do you use tobacco?	Yes / No	
Do you use alcohol?	Yes / No	
Do you use cocaine or other drugs?	Yes / No	Women Only:
Do you wear contacts?	Yes / No	Are you pregnant? Yes / No
Do you have any allergies?	Yes / No	Are you nursing? Yes / No
If yes, please explain: _____		Are you taking birth control? Yes / No
Have you ever had a reaction to anesthetic?	Yes / No	
If yes, please explain: _____		

Please answer all of the following:

High blood pressure	Yes / No	Frequently tired	Yes / No	Kidney disease	Yes / No
Heart attack	Yes / No	Anemia	Yes / No	AIDS/HIV infection	Yes / No
Rheumatic fever	Yes / No	Emphysema	Yes / No	STD's	Yes / No
Swollen ankles	Yes / No	Cancer	Yes / No	Thyroid problems	Yes / No
Fainting/seizures	Yes / No	Arthritis	Yes / No	Hepatitis A, B, or C	Yes / No
Asthma	Yes / No	Joint replacement	Yes / No	Ulcers	Yes / No
Low blood pressure	Yes / No	Chest pains	Yes / No	Respiratory problems	Yes / No
Epilepsy/Convulsions	Yes / No	Short of breath	Yes / No	Other:	_____
Leukemia	Yes / No	Stroke	Yes / No		_____
Diabetes	Yes / No	Hay fever/allergies	Yes / No		_____
Heart disease	Yes / No	Tuberculosis	Yes / No		_____
Cardiac pacemaker	Yes / No	Radiation therapy	Yes / No		_____
Heart murmur	Yes / No	Glaucoma	Yes / No		_____
Angina	Yes / No	Liver disease	Yes / No		_____

DENTAL HISTORY

Do your gums bleed while brushing or flossing?	Yes / No	Do you have frequent headaches?	Yes / No
Are your teeth sensitive to hot or cold liquids/foods?	Yes / No	Do you clench or grind your teeth?	Yes / No
Are your teeth sensitive to sweet or sour liquids/foods?	Yes / No	Do you bite your lips or cheeks frequently?	Yes / No
Do you feel pain in any of your teeth?	Yes / No	Have you had problems w/ previous dental work?	Yes / No
Do you have any sores or lumps in your mouth?	Yes / No	Have you ever had braces?	Yes / No
Have you ever suffered trauma to your face mouth or jaw?	Yes / No	How many times a day do you brush your teeth?	_____
Does your jaw ever click, pop, crackle or ache?	Yes / No	How often do you floss?	_____
Do you have pain in your jaw joint, ear or side of the face?	Yes / No	Do you use a manual brush or electric?	_____
Do you have difficulty opening or closing your mouth?	Yes / No	Do you use any type of mouth rinse?	_____
Do you have difficulty chewing?	Yes / No		

Goals for your mouth, teeth and smile:

If you could change anything about your smile, what would it be?

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

PATIENT SIGNATURE

DENTIST SIGNATURE

WITNESS SIGNATURE

PRINT NAME

DATE

DATE

DATE

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above \$500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- For patients with Dental Insurance:
 - Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
 - We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.
 - Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
 - All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 48-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of \$80.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a \$80 cancellation fee will be assessed for the first individual and \$50 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**
- Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- Treatment appointments made that **exceed \$500.00 will require 10% down** to hold the appointed time.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____

Signature _____ (Patient, Parent or Guardian)

This notice describes how medical/ dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 469-929-9370.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Floss City Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment. *Safeguarding Your Personal and Health Information*

We are required by law to:

- (1) make sure that medical information that identifies you is kept private
- (2) provide you with our privacy policy
- (3) follow the terms laid out in the privacy policy.

As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Floss City Dental maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of

Health and Human Services. The complaint in no way influences your course of treatment with Floss City Dental.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Floss City Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I have reviewed Floss City Dental's Privacy Policy.

Date _____

Signature _____ (Patient, Parent or Guardian)