Patient Information

(Please Print)

Legal Name: _____ Preferred Name (If different): _____ Male __ Female __
(Last) (MI) (First)

Marital Status: ____ Birth Date: _____ SS#: _____ Drivers License #: _____

Mailing Address:_____
(Street) (Apt#) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Ext: ____ Cell: _____

Email Address: _____ Whom may we thank for referring you? _____

Your Employer: _____

Responsible Party Information (or INSURANCE PRIMARY SUBSCRIBER)

Name: _____ Relationship: _____ Marital Status: ___
(Last) (MI) (First)

SS#: _____ Birth Date: _____ Drivers License #: _____ Male __ Female __

Home Address: _____
(Street) (Apt#) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Ext: ____ Cell: _____

Employment Information (FOR DENTAL INSURANCE PRIMARY SUBSCRIBER)

Employer Name: _____ Occupation: _____ Do you have Insurance? _____

Employer Address: _____
(Street) (Suite#) (City) (State) (Zip)

Primary Dental Insurance Information

Name of Insured: _____ Relationship: _____ Date of Birth: _____
(Last) (MI) (First)

SS#: _____ ID#: _____ Group #: _____ Male __ Female __

Insured Address: _____
(Street) (Apt#) (City) (State) (Zip)

Insurance Plan Name and Address and Phone:

_____

_____

_____

Do you have Secondary Coverage? _____, if so, we will give you the necessary information to assist you in filing for secondary coverage.

Emergency Information

In the case of an emergency, who may we contact? _____ Phone #_____

I affirm the information I have given is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and cannot be released to anyone without my consent. It is my responsibility, as the patient, to notify the office of any changes to my medical status. I authorize the Dental Solutions of East Texas staff to perform the necessary dental services I need.

Signature (Patient/Parent or Guardian of Minor): _____Date: _____

Office Policies and Payment Conditions

Payment is due at the time of service. We accept cash, checks, and major credit cards. We offer an outside financing option known as Wells Fargo Health Advantage. This Payment Plan may be utilized in accordance with Office Policies.

Benefits Plan/Insurance

This office will prepare insurance claims and assist in collecting from your insurance company. All money paid to the office will be credited to the patients account. In the event of an insurance over-payment or the insurance requests to be refunded, we will refund the insurance company. In the event your insurance does requests a refund, the patients account will be charged. This office cannot render services under the assumption that our charges will be paid by an insurance company. Patients who carry dental insurance must understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for all charges incurred, even in the event the procedure or procedures are deemed by your insurance as a non-covered procedure. This office and its Clinical Team follow the "Standard of Care" set by the State Board of Dental Examiners to assure you the best care possible. At the time of service, our office will estimate your portion based on benefit information given prior to your visit. **You will be expected to pay the estimated portion at the time services are rendered. This portion is only an estimate. A statement will be sent every month to keep you aware of your account. After 90 days, you will be responsible for any remaining balance your insurance has not paid on.**

Office Policies

All emergency dental services, or any dental services performed without previous financial arrangements must be paid in cash at time of services.

We respect your concern for your loved ones but due to the delicacy of our equipment and other patient privacies we request only the patient be present in the operatory. Additional family members must wait in our reception area.

Authorizations

I do hereby authorize Dental Solutions of East Texas and its staff to release all information necessary to secure the payment of benefits. I authorize the use of this signature on file for all insurance claim submission whether manual or electronic.

I do hereby authorize dental services for my child including, but not limited to, X-rays, treatment and administration of anesthetics deemed necessary or advisable by the Doctor, whether or not I am present at the appointment when treatment is rendered (if applicable, please initial _____).

I have read the above office policies and payment conditions and agree to their content. My signature below represents my agreement.

Signature: _____ Date: _____

(Signature of patient, parent/guardian)

Patient Health Information

Patient Name:_____ Date of Birth_____ Today's Date:_____

Are you currently under the care of a Physician? Please explain. Preferred Pharmacy:_____

Primary Physicians Name: _____ Phone Number: _____

Do you have or had any of the following? Please circle.

Aids	Artificial Joints/Heart Valve Replacements _____
Asthma	Blood Disease
Cancer (Specify_____)	Diabetes
Dizziness	Epilepsy
Excessive Bleeding	Fainting
Glaucoma	Growths
Hay Fever	Head Injuries
Heart Disease	Heart Murmur
Hepatitis (Specify _____)	High Blood Pressure
Jaundice	Kidney/Liver Disease
Mental Disorders	Nervous Disorders
Pacemaker	Respiratory Problems
Radiation Treatment	Rheumatism
Rheumatic Fever	Stomach Problems
Sinus Problems	Thyroid Disease
Stroke	Tuberculosis
Tumors	Ulcers
STD (Specify_____)	Other _____

Are you allergic to any of the following: (Please circle)

Aspirin	Penicillin
Codeine	Latex

Other drugs allergies : _____

Are you taking any of the following:

Aspirin	Insulin/Diabetic Drugs
Blood Thinners	Tranquilizers
Recreational Drugs	Steroids

Please List any prescription drugs you are currently taking: _____
Have you ever had any complications following dental treatment? (Y) (N) If yes, explain _____
Are you currently in dental pain? (Y) (N)
Do you need an Antibiotic Premedication before dental work? (Y) (N)
Do your gums bleed? (Y) (N)
Do you smoke cigarettes? (Y) (N)
Have you been admitted to the hospital or needed emergency care in the past 2 years? Explain _____

WOMEN ONLY: Are you taking Birth Control? (Y) (N) Type? _____ Could you be Pregnant? (Y) (N) (Unsure) Due Date:

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 Dental Solutions of East Texas Staff at the next appointment without fail.

Signature: _____ Date: _____
(Signature of Patient or Guardian)

Printed Name: _____

Health History Update Reviewed: Date:_____ Patient Initials:_____ Staff Initials:_____

Date:_____ Patient Initials:_____ Staff Initials:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Dental Solutions of East Texas

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 Dental Solutions of East Texas Staff.

I authorize the Dental Solutions of East Texas staff members to use any of my xrays and photos as educational and promotional tools for Dental Solutions of East Texas. Please note we do not show your face.
Please circle: YES NO X_____(initial)

I give my permission for the office to leave messages on my voicemail and/or email. YES_____ NO_____

Patient Name: _____

Relationship to Patient (if parent or guardian): _____

Signature of Patient/Guardian: _____

Date: _____