Patient Information

Patient Full Name _____ DOB _____ SS# _____

Home Address _____ Apt _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____ Ext_____ Email_____

Responsible Party Information

Your name: _____ Please provide the court order if another parent is responsible for a minor patient.

Legal Guardian name (if applicable) _____ Relationship to patient _____

SS# _____DOB _____Driver License # _____ State issued_____

Employer _____ Address _____City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____ Ext_____ Email_____

Dental Insurance Information

Full name of insured _____ SS# _____ DOB _____Relation to patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____ Ext_____ Email_____

Insurance Company _____ Customer Service or Provider Phone # _____ Payor ID _____

Insurance Company Address _____ City _____ State _____ Zip _____

Member ID _____ Employer/Group Name _____ Group/Policy # _____

Please let us know if you have secondary coverage _____

Financial Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment. We accept exact cash or credit card payments only, including Care Credit.

All dental services performed, including emergency treatment, must be paid for at the time services are rendered unless previous financial arrangements have been made. Financial arrangements may include any estimates on behalf of your dental insurance.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient, parent, or legal guardian who is legally responsible for the total cost of payment regardless of dental insurance. This office will file dental insurance claims and necessary documentation and will credit insurance payments to the patient's account. However, Tri-Cities Dental will not render services on the assumption that dental insurance will pay for your treatment.

I understand that any fee estimate will expire after six months from the date of diagnosis as fees are subject to fluctuate due to cost-of-living increases or changes made by my dental insurance company.

I authorize Tri-Cities Dental to file any appeal to the Texas Department of Insurance on my behalf and/or grant my permission to be notified at home or work by phone, text, or email for any matter relative to this form.

In consideration for any and all professional services rendered to me by the doctor, I agree to pay all fees at the time services are rendered. I understand that my insurance company does not and will not estimate fees over the phone or guarantee any payment until my claim is processed. I further agree that the cost of these services shall be as billed unless objected to, by me, in writing prior to the time services are performed. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and attorney fees if suit be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

Signature _____ Printed Name _____Date _____

Patient Name _____ DOB _____ Relationship to Patient _____

MEDICAL HISTORY - Do you have, or have you ever had, any of the following conditions:

Congenital heart disease, cardiovascular disease – like heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker?	Yes / No	Lung disease – like asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?	Yes / No
Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee?	Yes / No	Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily?	Yes / No
Kidney disease or kidney failure, requiring dialysis?	Yes / No	Liver disease – like jaundice, hepatitis A, B, or C?	Yes / No
Thyroid disease?	Yes / No	Arthritis?	Yes / No
Stomach ulcers or colitis?	Yes / No	Significant weight loss or gain?	Yes / No
Diabetes?	Yes / No	Sinus or nasal problems?	Yes / No
Glaucoma?	Yes / No	Sleep apnea?	Yes / No
Cancer?	Yes / No	Osteoporosis or osteopenia?	Yes / No
If yes, type_____		Anxiety, depression or other mental health disorders	Yes / No
Diagnosis date_____			
Treatments_____			

Do you have any other medical conditions that are important for your doctor to know about? Yes / No
If yes, please describe_____
_____

MEDICATIONS – Are you currently prescribed or taking any of the following:

Antibiotics?	Yes / No	Prescription pain medication?	Yes / No
Anticoagulants or blood thinners?	Yes / No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes / No
Heart medications?	Yes / No	Insulin or oral anti-diabetic drugs?	Yes / No
Steroids – like cortisone or prednisone?	Yes / No	Blood pressure medications?	Yes / No
Antianxiety agents, antidepressants, or other psychiatric medications?	Yes / No	Bisphosphonates or other medications to strengthen your bones?	Yes / No
Cancer or chemotherapy drugs?	Yes / No	Any other medications or supplements?	Yes / No

Please list the specific medications indicated above and/or any other medications <u>not listed above</u> that you are currently taking. Please including all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

Medication and dose	**Medication and dose**

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

Latex?	Yes / No	Codeine or other pain control medications?	Yes / No
Food or food products?	Yes / No	Aspirin, ibuprofen (Motrin), or naproxen (Aleve)?	Yes / No
Sedatives or barbiturates?	Yes / No	Penicillin or other antibiotics?	Yes / No
Any other medications?	Yes / No	Any other allergies?	Yes / No

If yes, please describe_____

MEDICAL HISTORY (Continued)

Please describe your current overall health: Excellent Good Fair Poor
Have there been any changes in your general health in the past year? Yes / No
If yes, please describe: _____

Are you now under a doctor's care for a medical condition? Yes / No Date of last physical exam?_____
If yes, please describe_____
Name of physician_____ Physician phone number_____

Have you ever been hospitalized or had a serious illness? Yes / No
If yes, please describe_____

Have you ever had surgery? Yes / No
If yes, please describe_____
_____
_____

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes / No
If yes, for how long?_____
Have you ever sought professional care or been hospitalized for:
Substance abuse Yes / No
Emotional disorders Yes / No
Alcoholism Yes / No

Do you use:
Alcohol? Yes / No If yes, how often per week?_____
Marijuana? Yes / No If yes, how often per week?_____
Recreational drugs? Yes / No If yes, how often per week?_____

DENTAL HISTORY

Please describe your current dental health: Excellent Good Fair Poor
Please describe why you are in the office today_____

Have there been any changes in your dental health in the past year? Yes / No
If yes, please describe_____

Are you having any dental discomfort at this time? Yes / No
If yes, please describe_____

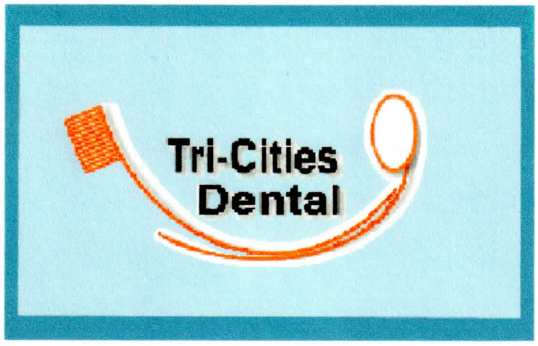
Have you had any adverse effects from dental treatment? Yes / No
If yes, please describe_____

Date of last dental visit?_____

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

_____ _____
Signature of patient, parent, guardian Date

_____
Printed name of patient, parent, guardian/Relationship



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

Tri-Cities Dental has posted their "Notice of Privacy Practices" and I understand that I may request a copy at any time.

Patient Name: _____

Signature of Patient, Parent if minor, or Legal Guardian_____

For Office Use Only

Tri-Cities Dental will complete this section if Patient, Parent, or Guardian Signature is not obtained.

Our office made a good faith effort to obtain the "Acknowledgement of Notice of Privacy Practices" receipt, but it could not be obtained due to the following reason:

_____ Patient refused to sign.

_____ Emergency situation.

_____ Language barriers.

_____ Other: _____.

Doctor of Office Staff Signature _____ Date _____.

Patient Reminders and Confirmations

It is your responsibility to keep your scheduled appointment. We call or send reminders and/or confirmations as a courtesy only and require that you let us know if you cannot keep a scheduled appointment.

If you need to cancel, reschedule, or change your appointment, we require a 24-hour notice for routine appointments and a 48-hour notice for any other treatment.

Tri-Cities Dental reserves the right to charge an initial $25 plus an additional $25 per each additional hour for any late/same-day cancellation or a missed appointment unless it is due to a life-or-death emergency.

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We send an email only one month before your scheduled appointment then an email or text reminder one week prior.

We will then send you a confirmation email or text (depending on your preference) and you must either answer with a "yes" or call our office if you wish to change, cancel, or reschedule your appointment. If you fail to confirm, you're appointment may be given to another patient who is waiting to be seen.

If you wish to be contacted in a way that we have not listed, you must submit your request in writing.

EMAILS AND TEXTS ARE NOT PRIVATE NOR CONFIDENTIAL

There is a valid reason why we ask patients to always call our office to discuss health matters.

Emails and texts are NOT HIPAA-approved methods for private healthcare information which is protected by confidentiality and privacy laws. They also carry an inherent risk of being intercepted and exploited (just like any personal email or text). We may, however, send messages that contain minimal and/or impersonal information such as appointment reminders, confirmations, lab case notices, etc...

However, detailed correspondence via these venues is not allowed for private healthcare professions.

I have read and am aware that additional information I convey or ask to be conveyed by either email or text is done at my own risk.

Patient name: _____

Signature of patient or legal guardian: _____

Date: _____