NICE FAMILY DENTISTRY

Patient Information:

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Preferred Name: _____

Address: _____ **City, State, Zip:** _____

Home Phone: (_____)_____ **Cellular Phone:** (_____)_____

Work Phone: (_____)_____ **EXT:** _____

Sex: *(circle one)* Male Female **Marital Status:** *(circle one)* Married Single Divorced Separated Widowed

Date of Birth: _____/_____/_____ **S.S.#**_____-_____-_____ **Driver's License #:** State:____#_____

Referred By: _____ **Preferred Pharmacy:** _____

Emergency Contact: _____ **Emergency Contact #:** (_____)_____-_____

Responsible Party Information: *(if someone other than the patient)*

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Preferred Name: _____

Address: _____ **City, State, Zip:** _____

Home Phone: (_____)_____ **Cellular Phone:** (_____)_____

Work Phone: (_____)_____ **EXT:** _____

Date of Birth: _____/_____/_____ **S.S.#**_____-_____-_____ **Driver's License #:** State:____#_____

Insurance Information:

Name of Insured: _____ **Date of Birth:** _____/_____/_____ **SS#**_____-_____-_____

Relationship to Insured: (circle one) Self Spouse Child Other

Employer: _____ **ID#:** _____ **Group#:** _____

Insurance Company: _____ **Telephone#** (_____)_____

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Medical History

Patient Name: _____ **Date Created:** ____/____/____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ____ Yes ____No **If Yes:** _____

Have you ever been hospitalized or Had a major operation? ____ Yes ____No **If Yes:** _____

Have you ever had a serious head Or neck injury? ____ Yes ____No **If Yes:** _____

Are you taking any medications, Pills, or drugs? ____ Yes ____No **If Yes:** _____

Do you take, or have you taken, Phen-Fen or Redux? ____ Yes ____No **If Yes:** _____

Have you ever taken Fosamax, Boniva, Actonel or any other meds containing Bisphosphonates? ____ Yes ____No **If Yes:** _____

Are you on a special diet? ____ Yes ____No **If Yes:** _____

Do you use tobacco? ____ Yes ____No **If Yes:** _____

Women: Are you…. (Circle if applies to you): **Pregnant** **Trying to get pregnant** **Nursing** **Taking oral contraceptives**

Are you allergic to any of the following? (Circle if applies to you) **Penicillin - Codeine - Acrylic - Metal - Latex - Sulfa Drugs - Local Anesthetic**

Other? _____

Do you use Controlled substances? ____ Yes ____No **If Yes:** _____

Do you have, or had any of the following?

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive			Cortisone Medicine			Hemophilia			Radiation Treatments		
Alzheimer's Disease			Diabetes			Hepatitis A			Recent Weight Loss		
Anaphylaxis			Drug Addiction			Hepatitis B or C			Renal Dialysis		
Anemia			Easily Winded			Herpes			Rheumatic Fever		
Angina			Emphysema			High Blood Pressure			Rheumatism		
Arthritis/Gout			Epilepsy or Seizures			High Cholesterol			Scarlet Fever		
Artificial Heart Valve			Excessive Bleeding			Hives or Rash			Shingles		
Artificial Joint			Excessive Thirst			Hypoglycemia			Sickle Cell Disease		
Asthma			Fainting / Dizziness			Irregular Heartbeat			Sinus Trouble		
Blood Disease			Frequent Cough			Kidney Problems			Spina Bifida		
Blood Transfusion			Frequent Diarrhea			Leukemia			Stomach/Intestinal Disease		
Breathing Problems			Frequent Headaches			Liver Disease			Stroke		
Bruise Easily			Genital Herpes			L:ow Blood Pressure			Swelling of Limbs		
Cancer			Glaucoma			Lung Disease			Thyroid Disease		
Chemotherapy			Hay Fever			Mirtal Valve Prolapse			Tonsillitis		
Chest Pains			Heart Attack/ Failure			Osteoporosis			Tuberculosis		
Cold Sores/ Fever Blisters			Heart Murmur			Pain in Jaw Joints			Tumors or Growths		
Congenital Heart Disorder			Heart Pacemaker			Parathyroid Disease			Ulcers		
Convulsions			Heart Trouble/ Disease			Psychiatric Care			Venereal Disease		

Have you ever had any serious illness not listed above? *Yes_____ No_____ If Yes:* _____

*Comments:*_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

_____ **Date:** _____/_____/_____

NICE FAMILY DENTISTRY

Patient Dental History

Patient's Name: _____ Date: _____/_____/_____

Reason for this visit: _____
When was your last dental visit?: _____ What was done then?: _____
How often did you visit the dentist before then? _____
Previous dentist: Name: _____ Location: _____
Have you had a complete series of dental films (X-Rrays) taken? When_____ Where_____

	Yes or No		Yes or No
Are your teeth sensitive to hot or cold?	_____ ☐	Have you ever had any prolonged bleeding after extractions?	_____ ☐
Ever worn a bite plate or other appliance?	____ ☐	Does food tend to become caught between your teeth?	_____ ☐
Are your teeth sensitive to sweet or sour?	____ ☐	Do you wear dentures or partials?	_____
Do you feel pain to any of your teeth?	_____ ☐	if Yes, date of placement:	_____ ☐
Have you ever had any difficult extractions in the past?	_____		

TMJ:

Do you have frequent headaches? _____
Do you have pain in or around your jaw joint? _____ Right side - Left side
When is the pain worse? _____ Mornings / Evenings / At meals / No specific time
Do you have clicking, popping, or grating noise in you jaw joint?_____ Right side - Left side
Has your mouth ever locked open so you were unable to close it?_____
Have you ever had problems opening your mouth wide?_____
Are you aware of clenching your teeth? _____If Yes, When? _____
Do you grind your teeth? _____ If Yes, When? _____
Are you taking, or have you taken medication for this problem? _____

PERIODONTAL:

Do you feel you have consistent bad breath? _____
Do you have bleeding when brushing or flossing? _____
Do you have red, swollen or tender gums? _____
Do you have receding gums? _____
Have you previously been diagnosed with gum disease? _____

Times per day: Brushing:_____ Flossing:_____Mouthwash:_____

SMILE EVALUATION:

Do you like the way your teeth look? _____
Would you like your teeth to be whiter? _____
Would you like your teeth to be straighter? _____
Do you have spaces between you teeth that you would like closed?_____
Do you like the shape of your teeth? _____
Do you have missing teeth that you would like to replace? _____
Would you like to replace old silver fillings with tooth colored fillings? _____

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

410 N. Gun Barrel Lane
Gun Barrel City, TX 75156

Office Financial Policy

We feel the best thing about our style of dentistry is our commitment to quality. If you've been with our practice a while, you already know our attention to detail and fine materials are second nature to us. Everyone's financial situation is different, and good dentistry won't count for much if it is beyond your means. Please review our office financial policy, If you share our belief in quality dentistry--the best dentistry we can possible do--then we'll find a way to make it part of your life financially.

In order to pay for lab services, staff members, materials and to keep our billing costs down, our office payment policy is: **Payment due upon initial day of service.**

We accept **cash**, **check**, **bank cards** (Visa, Master Card, American Express, Discover), and **Care Credit**. *[Care Credit: a healthcare credit card, with a no interest (if paid within promotional period) or low fixed interest payment plan. **Subject to credit approval.]*

Insurance and co-pays
Our office has always been happy to work with patients covered by dental insurance. We think insurance is a great incentive to maintain a vital level of dental health. It is rare--very rare—that a dental plan covers 100% of all fees. Here's why:

The fees we charge for dental services are the same for every patient, insured or not. A given insurance policy, however, is based on a fixed fee schedule--"usual and customary"--that may have nothing to do with the real world. Dentistry has changed very quickly, insurance fee schedules have not. After all, insurance companies are profitable businesses, not dental benefactors.

Further, insurance companies reimburse you an amount they figure is comparable with average quality dentistry in an average office with an average staff, "average" falling somewhere between the best dentistry and the worst dentistry.

We work with most dental insurers. We'll fill out your claim forms with you and answer any questions we can. Please keep in mind you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. We do ask that you pay your ***estimated*** portion at each visit. Please note that we can only give you an ***estimate***, after the dental insurance payment is received, if an additional balance occurs for the insured, a statement will be sent explaining the patient balance.

We're happy to help you with any insurance questions you have. We'll go over your policy with you, try to maximize your benefits, and request a predetermination of benefits to let you know what your insurance will pay. Please remember your employer purchased your plan and your insurance company dictates your coverage--we don't.

I have read the above policy, and agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Responsible Party Signature **Date**

Patient Consent & Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: ____/____/____

Address:_____

Street *City* *State* *Zip Code*

Patient Authorization

I hereby authorize the release, use or disclosure of my health information as follows:

This authorization pertains to the following type of medical information about me: Protected health information to carry out treatment, payment activities, and healthcare operations.

I hereby authorize Joshua Niswonger, D.D.S. to release the above described information to other healthcare providers, insurance companies, or third party healthcare operations as needed.

I understand that, per my request, this authorization will permit the above named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I understand that I may revoke this authorization at any time by providing written notification to: *Joshua Niswonger, D.D.S. 419 N. Gun Barrel Lane, Gun Barrel City, Texas 75156*

The revocation will be effective on the date it has been received and processed by the above – named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment or to enroll or be eligible for benefits.

Unless I request in writing otherwise, I understand that this authorization will expire upon the closure of Joshua Niswonger, D.D.S. practice.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Patient or Personal Representative

Signature: _____ Date: ____/____/____

Name: _____ Relationship to Patient:_____

Please Print

For Office Use Only

Received by: _____ Date: ____/____/____

NICE FAMILY DENTISTRY