PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Preferred name _____ Birth date _____

If minor, parents names _____ Home phone _____ Work phone _____

Cell Phone _____ E- Mail _____

Mailing address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____ ❑ Unmarried

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

Emergency Contact _____ Number _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co. _____ Group number _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor _____
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Is Pre Med required _____
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve _____
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems _____
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease _____
- ❑ Alcoholism
- ❑ Blood transfusion _____
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin
- ❑ Other antibiotics _____
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other: _____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other: _____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

Please list any medication you are taking and why: _____

Signature of patient (or parent) _____ **Date** _____

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Family Smiles Dental Group (dba)

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Family Smiles Dental Group (dba). The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Family Smiles Dental Group (dba) reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	☐ **YES**	☐ **NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (i.e. Parents, Grandchildren, Aunts, Uncles)	☐ **YES**	☐ **NO**
OTHER:	☐ **YES**	☐ **NO**

Name of patient (please print):

Patient signature (if 18+ years of age):

Patient's personal representative: (Please Print):

Personal Representative's signature:

Representative's Telephone Number: **Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:**
Reason for not obtaining patient signature:	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

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FamilySmiles
DENTAL GROUP

Our goal is to provide the best level of dental care we can and to keep the cost down as well. In an effort to do this we have established the following financial policies for payment of treatment:

1. Payment in full is due at each visit unless prior arrangements have been made. We accept cash, check, credit/debit cards and Care Credit. We do have outside financing available, with approved credit, through Lending Club Patient Solutions.

2. A 10% discount is offered for all treatment PAID IN FULL by cash or check. A 5% discount is offered if paid with credit/debit cards. This discount does not apply to any discount fee plans.

3. We do accept assignment of benefits from your insurance company. Accurate information must be on file and verified prior to treatment. Your co-payment is due at the time of treatment. You are responsible for any non-covered or denied balance within 30 days of receipt of the insurance payment.

4. If unable to keep your appointment please notify us within 24 hours prior. Failure to do so may result in a broken appointment fee.

5. Returned checks are subject to a $40 service fee.

6. If you do not have dental insurance we have a discount plan available, ask for details.

I have read, understand and agree to the terms described above.

_____ _____

Patient/Parent Date

2650 Firewheel Dr, Flower Mound, TX 75028
972-539-0608

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