PATIENT INFORMATION

FULL NAME	PREFERRED NAME	BIRTH DATE	AGE	SEX M F
ADDRESS	CITY	STATE	ZIP	
EMAIL ADDRESS TO BE USED FOR BILLNG	PRIMARY DAYTIME PHONE	OTHER PHONE		
EMPLOYER / SCHOOL	EMPLOYER PHONE	STATUS *FULL TIME PART TIME RETIRED*		
EMPLOYER ADDRESS	EMPLOYER CITY	STATE	ZIP	
OCCUPATION	DL#	MARITAL STATUS S M D W		
EMERGENCY CONTACT (*NOT IN SAME HOUSEHOLD*)	RELATIONSHIP	PHONE		

VISIT INFO

REASON FOR VISIT	ACCIDENT RELATED? *WORK AUTO OTHER*	DATE OF INJURY

IF YOUR VISIT IS FOR AN IMPLANT:

❑ *TOOTH IS IN PLACE* ❑ *TOOTH WAS REMOVED / LOST ON* _____ *(approximate date)*

REFERRED BY	FAMILY OR FRIEND WHO HAS SEEN US	PHARMACY PHONE NUMBER
DENTIST	PRIMARY CARE PHYSICIAN NAME / PHONE	ORTHODONTIST

PARENT -RESPONSIBLE PARTY FOR CHILDREN OR DEPENDANTS

PERSON ACCOMPANYING PATIENT	BIRTH DATE	RELATIONSHIP TO PATIENT	
ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIP
EMAIL ADDRESS (IF DIFFERENT FROM PATIENT-USED FOR BILLING)	PRIMARY DAYTIME PHONE	OTHER PHONE	
OCCUPATION		DL#	
EMPLOYER / SCHOOL	EMPLOYER PHONE	STATUS *FULL TIME PART TIME RETIRED*	
EMPLOYER'S ADDRESS	EMPLOYER CITY	STATE	ZIP

PRIMARY DENTAL INSURANCE

INSURANCE COMPANY NAME	
INSURANCE COMPANY PHONE	
POLICY HOLDER FULL NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT *PARENT SPOUSE OTHER*
STREET ADDRESS	
CITY, STATE, ZIP	
SS / POLICY NUMBER	
GROUP NUMBER	
EMPLOYER	

COMPLETE THIS SECTION

Pharmacy Information for Medications

PHARMACY NAME
PHARMACY PHONE
PHARMACY FAX
STREET ADDRESS

TDS

TEXAS DENTAL SURGERY

IMPLANTS • ORAL SURGERY • PERIODONTICS

FEES & PAYMENTS

Thank you for choosing Texas Dental Surgery for your oral surgery and periodontal care.

We share your concerns regarding the increasing cost of health care. We believe that you, our patients, expect and deserve the highest quality care we provide at a reasonable cost. While we take advantage of every possible avenue to keep costs down, we are committed to not sacrificing quality for less expensive care. With this in mind, we would like to share some information with you about our financial policy. We hope you will consult with us if you have any questions regarding our services and our financial policies.

Many people are under the impression that if they have insurance, it is the Insurance Company who owes the doctor for services. Please keep in mind, the insurance contract is between the patient and the insurance company. **Therefore, the patient is responsible for the bill, regardless of insurance coverage determination. As a courtesy to our patients, we are happy to bill your PRIMARY insurance for you, however, the responsibility for payment remains with the patient (or insured).**

CANCELED APPOINTMENTS: We reserve the right to charge $50-$200 for appointments / surgeries canceled or broken without 24-hour advance notice.

PATIENTS WITH INSURANCE: At the time of surgery patients are **REQUIRED** to make an initial surgery deposit toward the **ESTIMATED CHARGES.**

As a courtesy, we will assist you in **ESTIMATING** your coverage. The actual amounts of coverage may vary from this **ESTIMATE**. **Many insurance plans state that you will be covered up to "50%, 80%, 100%". Despite that statement, we have found that many plans may cover less than that depending on their established "usual and customary fees" and what services they actually cover.** Please be aware that some insurance companies will pay a claim percentage based on their "**usual and customary fees**", not our actual charges. To determine what portion of your bill will be covered by insurance, we will gladly request a pre-authorization by your carrier, however, this may require up to eight weeks to be processed by the insurance company.

PATIENTS WITHOUT INSURANCE: Patients without insurance are required to make full payment at the time of surgery. We do not routinely finance surgical fees.

PATIENT FINANCING: We participate in CareCredit that allows patients to finance their treatment through this third-party lender. You can apply by visiting www.carecredit.com.

CHECKS: There will be a $38.00 charge for all returned checks.

ACCOUNT BALANCES: The balance on all accounts is due in full in 60 days regardless of insurance coverage or anticipated payment from other sources. If payment for our services is not made within 60 days of receipt of services, an interest charge of 1.5% per month will be added to the account (18% per annum). Therefore, patients with insurance whose claims have not been paid within 30 days should contact their insurance company to determine the reason for the delay of payment. You will be responsible for all collection costs and reasonable legal costs, in addition to the amount originally owed.

ASSIGNMENT AND RELEASE: For individuals in insurance, your signature below hereby authorizes your insurance benefits to be paid directly to the doctor. You are still financially responsible for any balance due. It also authorizes the doctor to release any information required for payment and processing of this claim.

AGREEMENT: I have read and understand the financial policy of the practice and I agree to be bound by its terms.

Signature of Patient (Parent of Guardian if Minor) Date:

_____

Patient Name _____ DOB ____/____/____

HEALTH HISTORY

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? _____

		Yes	No
1.	**Height** _____ **Weight** _____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you in the care of a physician? **Date of last visit** _____	❑	❑
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
5.	**If so, describe where** _____		
6.	Do you have a prosthetic joint / implant? **If so, describe where** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you ever had general anesthesia?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic Fever?			
12. Damaged heart valves, mitral valve prolapse?			
13. Heart Murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heartbeat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / lung issues?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke or vape? If so, how much a day?_____			
30. Do you use chewing tobacco?			
31. Blood transfusion?			
32. Blood disorder such as anemia?			
33. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Infectious mononucleosis?			
37. Gallbladder trouble?			
38. Fainting spells?			
39. Convulsions / epilepsy?			
40. Asperger's / Autism?			

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
41. Stroke?			
42. Thyroid Trouble?			
43. Diabetes?			
44. Low blood sugar?			
45. Kidney trouble?			
46. High cholesterol?			
47. Are you on dialysis?			
48. Swollen ankles / arthritis / joint disease?			
49. Osteoporosis / osteopenia?			
50. Osteonecrosis?			
51. Stomach ulcer / acid reflux?			
52. COVID-19?			
53. Contagious diseases?			
54. Sexually transmitted diseases?			
55. Problems with immune system? Possibly from medication / surgery, etc.			
56. Autoimmune disease?			
57. Delay in healing?			
58. A tumor or growth?			
59. Cancer / radiation therapy / chemotherapy?			
60. Chronic fatigue / night sweats?			
61. Are you on a diet?			
62. A history of alcohol abuse?			
63. A history of marijuana or other drug use?			
64. Contact lenses?			
65. Eye disease / glaucoma?			
66. Mental health problems / anxiety / depression?			
67. A removable dental appliance?			
68. Pain or clicking of jaws when eating?			

OFFICE USE ONLY	ASA Category:	BP: /	P:	R:

WOMEN ONLY: (QUESTIONS 68-71)

	Yes	No		Yes	No
69. Is there a possibility of pregnancy?	❑	❑	71. Are you nursing?	❑	❑
70. Expected delivery date? _____			72. Are you taking birth control pills?	❑	❑

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.

ARE YOU CURRENTLY TAKING:	YES	NO	NOTES
73. Any kind of medication, drug, pills?			
74. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Xarelto, Eliquis, Fish oil)?			
75. Have you ever taken diet pills?			
76. Any natural product, herbal supplement or homeopathic remedy?			
77. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Prolia, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Xgeva, or Evista in the past 12 years?			

78. Tranquillizers, sleeping pills, anti-depressants, and / or narcotics on a regular basis? If so, please list:

79. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ❑Methadone ❑Suboxone ❑Oxycodone ❑Fentanyl ❑Other _____
Treating Doctor: _____

80. Please list any medications you are currently taking:

Medication	Dosage	Frequency

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑Yes ❑No
Who is driving you home? _____

Is there any condition concerning your health that the Doctor should be told about? ❑Yes ❑No - If Yes, describe:

Do you wish to speak to the Doctor privately about anything?
❑Yes ❑No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
81. Local anesthetic (numbing meds)?			
82. Penicillin?			
83. Other antibiotics?			
84. Sulfa drugs?			
85. Sodium pentothal / Valium / other tranquilizers?			
86. Aspirin?			
87. Amoxicillin?			
88. Codeine or other narcotics?			
89. Latex?			
90. Soy?			
91. Eggs / yolk?			
92. Sulfites?			
93. Do you have any known allergies?			

94. Please list any allergies other than drug allergies:

95. Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic Name

Is there a family history of:
❑Cancer ❑Diabetes ❑Heart Disease ❑Anesthesia problems

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

DATE _____ SIGNATURE OF PERSON COMPLETING HEALTH HISTORY _____ DOCTORS INITIALS _____

Medical Update: I have read my Health History dated and confirm that it adequately states past and present conditions.

DATE _____ SIGNATURE OF PATIENT _____ DOCTORS INITIALS _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ have read a copy of this office's Notice of Privacy Practices.

Signature: Date:

Authorized person(s) to receive information from our office:

Financial or Scheduling Information

_____

_____

Medical Information

_____

_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

CONSENT FOR ELECTRONIC COMMUNICATIONS, EMAIL, TEXT MESSAGING

You have requested our practice communicate with you electronically. By utilizing our practice's electronic services, you agree that Texas Dental Surgery may send to you any of the following that you identify as communication that can be sent through text, or the internet to an email address you designate.

Consent and Acknowledgement

I _____, in the presence of my dentist or the dental practice's privacy official, agree that the practice may electronically communicate with me at the following email address:

Email Address: _____ DOB: _____

I acknowledge that the practice may send the following to my email. *Check each that apply, and then provide your initials at the end of each item selected.*

- ☐ Information about my invoice or accounts payable _____
- ☐ Information about a treatment plan _____
- ☐ Information about any dental visit _____

Acknowledgement

You must acknowledge each of the following before we can send communication electronically.

- ☐ I am responsible for providing the dental practice any updates to my email address.
- ☐ I am able to receive information electronically and store it securely away from any public computer.
- ☐ I can withdraw my consent to electronic communications by calling 469-296-8680.

Signature: Date: