TEXAS DENTAL SURGERY

IMPLANTS · ORAL SURGERY · PERIODONTICS

PATIENT INFORMATION

Today's Date:_____

NAME_____ HOME PHONE_____ WORK PHONE_____

EMAIL_____ CELL PHONE_____

HOME ADDRESS_____ CITY_____ ZIP CODE_____

SOC. SECURITY#_____ DATE OF BIRTH_____ AGE_____

PLACE OF EMPLOYMENT_____ OCCUPATION_____

SPOUSE/PARENT NAME_____ WORK PHONE_____

SPOUSE/PARENT PLACE OF EMPLOYMENT_____ SS #_____

NEAREST RELATIVE NOT LIVING WITH YOU_____ PHONE_____

NEAREST FRIEND NOT LIVING WITH YOU_____ PHONE_____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?_____ PHONE_____

PHYSICIAN_____ PHONE_____

GENERAL DENTIST_____ PHONE_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?_____

DO YOU HAVE DENTAL INSURANCE? Yes☐ No☐ MEDICAL INSURANCE? Yes☐ No☐

DENTAL HISTORY

Date of last dental cleaning and check-up_____

DO YOU:	Yes	No
Have pain in your mouth.....	☐	☐
Where_____		
Have frequent headaches.....	☐	☐
Have popping or clicking joints in front of your ears.....	☐	☐
Have pain in the joints in front of your ears.....	☐	☐
Clench or grind your teeth (circle which).....	☐	☐
Have frequent problems with bad breath.....	☐	☐

ALSO:

When were you first told of your periodontal (gum) problems_____

Use tobacco products: which and how much?_____

_____

Drink alcohol: How much_____

HAVE YOU:	Yes	No
Had gum surgery.....	☐	☐
Had periodontal scaling (deep cleaning).....	☐	☐
Noticed bleeding gums when you brush.....	☐	☐
Had any teeth shift recently.....	☐	☐
Had orthodontics (braces).....	☐	☐
Ever had a serious injury or blow to your mouth.....	☐	☐
Had your wisdom teeth removed.....	☐	☐

If yes, when_____

DENTAL CARE:

How often do you brush_____

How often do you floss_____

Which kind of toothbrush do you use_____

List any other oral hygiene products you use_____

_____

How often do you have dental cleanings and check-ups_____

Last Cleaning and Check-up:_____

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FEES & PAYMENTS

Thank you for choosing Texas Dental Surgery for 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 insurances plans state that you will be covered up to "50%, 80%, 100%". In spite of that statement, we have found in actuality that many plans may cover less than that depending upon 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.** In the event that payment for our services is not made within 60 days of receipt of services, and 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 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 with 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 term.

Signature of patient: (Parent or Guardian if Minor) Date:

_____

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MEDICATIONS

Patient name:_____ **Date:**_____

Please List the Names of Any: 1. Prescription Medicine 2. Over the Counter Medicine 3. Herbal Medicine 4. Vitamin 5. Street Drug	**Dosage** (mg)	**How Often Is it Taken**	**Disease Being Treated or Reason For Taking**	**Prescribing Doctor or Self Prescribed**

TDS TEXAS DENTAL SURGERY

OFFICE USE ONLY

ASA Category:_____

BP:____/____

P:_____ R:_____

HEALTH HISTORY

PATIENT'S NAME

DATE *All Responses Are Kept Confidential*

ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

6. Height _____ Weight _____

7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N

8. ARE YOU USING ANY OF THE FOLLOWING:
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ..... Y N
   - D. High Blood Pressure medications. ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? ..... Y N
   - I. Are you presently taking, or have you ever taken any of the following Bisphosphonate Medicines:
     - Etidronate (Didronel) ..... Y N
     - Tiludronate (Skelid) ..... Y N
     - Alendronate (Fosamax) ..... Y N
     - Risedronate (Actonel) ..... Y N
     - Ibandronate (Boniva) ..... Y N
     - Pmidronate (Aredia) ..... Y N
     - Zoledronate (Zometa) ..... Y N
     - Zoledronic Acid (Reclast) ..... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals (Use back of form if necessary):

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N

10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. FOR WOMEN ONLY
    - A. Are you Pregnant, or Is there any chance you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

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 _____ DOCTOR'S INITIALS _____

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

DATE _____ EXCEPTIONS OR CHANGES _____ PATIENT'S SIGNATURE _____ DOCTOR'S INITIALS _____

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CONSENT FOR ELECTRONIC COMMUNICATION, 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:_____

Patient's Date of Birth (for verification purposes)_____

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 _____ (initials)
- Information about a treatment plan _____ (initials)
- Information about any dental visit _____ (initials)

Acknowledgement

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

_____ I am responsible for providing the dental practice any updates to me 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.

Patient's Signature _____ Date _____

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ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(There is a copy located on our website – www.txdentalsurgery.com or by request in our office.)

You may refuse to sign this acknowledgement

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

___ Communications barriers prohibited obtaining the acknowledgment

___ An emergency prevented us from obtaining acknowledgement

___ Other (Please specify) _____