Parmer Lane Family Dentistry ♦ 3704 West Parmer Lane ♦ Austin, TX 78727 ♦ 512.255.7001 ♦
www.keepaustinsmiling.com ♦ office@keepaustinsmiling.com

Welcome!!!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us become better acquainted, please fill out this form completely in ink and sign all the pages. If you have any questions or concerns, please let us know.

PATIENT INFORMATION (CONFIDENTIAL)

Full Name: _____ What would you like us to call you? _____
Address: _____ City: _____
State & Zip: _____ Age: _____ Sex: _____ Birthdate: _____ Marital Status: _____
Home Phone: _____ Work Phone: _____Mobile/Pager #: _____
E-mail Address: _____ Would you like a reminder call for your appointments? ☐ YES ☐ NO
How would you like us to verify your appointments? ☐ HOME PHONE ☐ WORK PHONE ☐ MOBILE/PAGER ☐ E-MAIL
Social Security #: _____ Driver's License #: _____
Employer Name (Patient/Parent's): _____
Employer's Address: _____
Whom may we thank for referring you? _____
Main reason for your visit today? _____
Previous Dentist: _____ Date of Last Dental Visit: _____

PARENT *(for minors)* /SPOUSE INFORMATION *(Please fill out completely.)*

MOTHER or WIFE	**FATHER or HUSBAND**
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Work Phone:	Work Phone:
DL# DOB:	DL# DOB:
SS#	SS#

Person Financially Responsible: _____
****Please list any of your family members who are patients in our office?** _____

PATIENT DENTAL HISTORY	**YES**	**NO**
Do you floss regularly?		
Have you ever had instruction on the correct method of brushing your teeth?		
Have you had any instructions on the care of your gums?		
Are your teeth sensitive to hot or cold liquids/foods?		
Are your teeth sensitive to sweet or sour liquids/foods?		
Do you feel pain in any of your teeth?		
Do you have any sores or lumps in or near your mouth?		
Have you had any difficult extractions in the past?		
Have you had any prolonged bleeding following an extraction?		
Have you had any orthodontic work?		
Is there anything about the appearance of your teeth that you would change? (What?)		
Have you had any bad experiences in a dental office? If yes, please briefly explain		

I authorize Parmer Lane Family Dentistry to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

_____
Signature of patient (or parent if patient is a minor)

HEALTH INFORMATION

Medical Physician _____ Office Phone _____ Last Visit _____
Are you under medical care now? (If so, please describe) _____
_____
Please list any medications you are taking (including non prescription) _____
_____
Do you use tobacco products? (Re: cigarettes, smokeless tobacco) _____

Do you have or have you had any of the following health problems? All information is confidential and helps us determine what medicines and treatments are best for you. **(Be sure to fill chart out completely.)**

★ If you have any of the starred conditions, please call the office prior to your appointment... Pre medication may be required.

Yes	No		Yes	No	
		Diabetes			Organ Transplant ★
		Kidney Dialysis ★			Joint Replacement ★ or Implant ★
		Rheumatic Fever ★			Radiation Treatment
		Heart Murmur ★			Stroke
		Valve Disorders ★			Anemia
		Heart Trouble, Heart Attack			Frequently Tired or Easily Winded
		Heart Disease			Liver Disease
		Cardiac Pacemaker			Ulcers, Stomach or Mouth
		High or Low Blood Pressure (Please specify)			Respiratory Problems, Tuberculosis
		Asthma			Eye or Ear Problems
		Hepatitis (Specify A, B or C) Year:			Epilepsy or Seizures
		Frequent Illness, Lowered Immunity			Venereal Disease, any type
		Bleeding Disorder, Hemophilia			Unusual Weight Loss or Gain
		Blood Transfusions Reason:			HIV + or AIDS
		Cancer, Tumors, Cysts			Other

Allergies (Please answer yes or no- do not leave blank):
Are You Allergic To Penicillin? _____ Local Anesthetics? _____ Aspirin? _____ Iodine? _____ Codeine? _____
Sulfa Drugs? _____ Latex Rubber? _____ Please list any other allergies to medication: _____

Is there any other health information we should know? _____
Are You Pregnant? _____ Due Date: _____ Nursing? _____Oral Contraceptives? _____ **(Please inform us if you become pregnant.)**

Please inform us if your health information should change.
Whom should we contact in case of an emergency? **(Please do not leave this blank)**
Name:_____Phone?_____Relationship?_____
Closest relative or friend not living with you? _____ Phone: _____

To my knowledge the above information is correct and complete. I understand that providing incorrect information can be dangerous to my health. If the patient is a minor, permission is hereby given for dental treatment as deemed necessary to be performed in our office or until written notice is given discontinuing this permission. I agree to be financially responsible for all expenses incurred for myself or my dependents.

_____Date:_____
Signature of patient (or parent if patient is a minor)

★OFFICE USE ONLY★

Reviewed By Dentist: _____ Date: _____

MEDICAL UPDATES (to be filled out at future appointments)

DATE	PATIENT'S/ GUARDIAN'S SIGNATURE	CHANGES IN MEDICAL HISTORY	Doctor's Initials

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FINANCIAL INFORMATION

(Please be sure to fill out completely.)

Dental Insurance

We will be happy to file your primary insurance for you, provided they will pay us directly. You will be responsible for filing any secondary insurance. All co-insurance and/or deductibles are due when services are rendered.

Name of Employee: _____ Relationship to Patient: _____
Date Employed: _____ Employee ID# (if applicable): _____
Employer's Name & Address: _____
_____
Group #: _____ Effective Date: _____
Insurance Company Name: _____
Insurance Company Address (Claims Address): _____
City, State, Zip: _____
Phone Number to Verify Benefits (800 #): _____

I authorize Parmer Lane Family Dentistry to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

_____
Signature of patient (or parent if patient is a minor)

Assignment of Benefits

I hereby authorize payment of dental benefits otherwise payable to me directly to Parmer Lane Family Dentistry.

_____
Signature of patient (or parent if patient is a minor)

Referrals

Occasionally, it may be necessary to refer patients to another medical / dental professional. If using your medical insurance for any treatment, you may need a referral authorization from your medical carrier in order to receive benefits. If a referral is necessary, the dentist may need to speak with another healthcare practitioner. This may include protected health information and treatment records.

I understand that I am responsible for attaining any referral authorizations necessary for my medical insurance. I authorize Parmer Lane Family Dentistry to release any information including health information, diagnosis and the records of any treatment or examination rendered to me or my dependents to health practitioners.

_____
Signature of patient (or parent if patient is a minor)

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DON'T WAIT TILL IT HURTS

Name: _____

Periodontal Disease is painless. It affects 87% of the population, most of which are unaware of the problem. There are warning signs and we want you to be aware of them.

1. Do your gums bleed when you brush, floss or use a toothpick?

   YES _____ NO _____

2. Are your gums red, swollen or tender?

   YES _____ NO _____

3. Are your gums pulling away from your teeth?

   YES _____ NO _____

4. Do you see pus between your teeth and gums when the gums are pressed?

   YES _____ NO _____

5. Are your permanent teeth loose or separating?

   YES _____ NO _____

6. Has there been any change in the way your teeth fit together when you bite?

   YES _____ NO _____

7. Do you have chronic bad breath?

   YES _____ NO _____

IF THE ANSWERS TO ANY OF THESE QUESTIONS IS "YES", YOU OWE IT TO YOURSELF TO TELL YOUR DENTIST OR HYGIENIST. DON'T WAIT UNTIL IT IS TOO LATE.

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Payment Information

Thank you for choosing us as your dental health care provider. Our commitment is to provide state of the art dentistry for our patients. We will deliver treatment in a timely manner and at a reasonable fee. We are committed to providing you with all the information that you need in order to make an informed decision regarding your treatment. In doing so, we would like discuss payment options that may be available to you.

Payment is expected at the time of service. We accept cash, approved checks, American Express, Visa, MasterCard, Discover, CareCredit and Debit Card payments. We have financing options available through CareCredit and Chase Healthcare Financing.

We will look to the adult accompanying a minor for payment on all services rendered to a minor patient.

We understand dental benefit plans, and will gladly assist you in obtaining the maximum benefit as specified by your contract.

It is important, however, that you are aware of the following:

- We are not a contracted provider with any dental insurance company. We are not a DMO provider.
- Your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. In order to file and estimate your benefits, it is imperative that you provide us with the necessary information. (Claims address, telephone numbers, group/policy number and benefit information.) *As a courtesy to you, we will file your primary dental claims. If you have secondary insurance, we would be happy to assist you in filing those claims with the benefits paid directly to you.*
- All insurance companies are not the same. As such, not all **necessary** dental services are a covered benefit in all contracts. We encourage you to read through your benefits booklet provided to you by your carrier.
- You, *not the insurance company*, are responsible for all of our fees.
- If your insurance company does not pay your claim within 60 days from the date of service, we will require that you pay the balance in full and have your dental insurance pay you directly.
- We are happy to provide you with an ESTIMATE OF BENEFITS for your dental treatment. We will base our *estimate* on information provided to us by you and your insurance company. Please realize- all information given to us by an insurance company is an "estimate" and not a guarantee of how they will pay a claim.
- Any co-insurance is expected at the time service is rendered. Any payments made to the office at the time of treatment are intended to go towards your total patient portion and may not be your final financial responsibility.
- If your insurance company will not pay us directly, you will be responsible for all fees at each appointment. We will file the claims for you and your insurance company will pay you directly. (Ex: Delta Dental)

We will be happy to discuss your proposed dental treatment and answer any questions that you might have regarding your dental benefits.

Because your time is important, it is our commitment to see you promptly. Your appointment is scheduled <u>just for you</u> and any change in your appointment affects many people. We appreciate your timely arrival.

In the event that missed appointments and /or changes in your schedule occur on a regular basis, a deposit will be required to reserve an appointment for you.

Some patients prefer to have long appointments to avoid more frequent visits and we are happy to schedule appointments of 2 hours or more for our patients. A deposit of ¼ the treatment amount is due when the appointment is scheduled. The deposit will be forfeited if the appointment is canceled with less than 48 hours notice.

If a balance remains on your account for any reason, a finance charge of 1.5 % per month (18% annual percentage rate) may be imposed on the unpaid balance at the end of each billing cycle.

In the event that your account is turned over to a collection agency, you are responsible for the balance, any finance charges, as well as all collections and/or attorney's fees.

I have read and understand the above information. I have had the opportunity to ask questions that have been answered to my satisfaction.

Patient Signature: _____ Date: _____
Please let us know if you would like a copy of this for your records.