

Patient Information Form

Name: _____ Date of Birth: _____
Social Security #: _____ Drivers License: _____
Home Address: _____ City: _____
Home Phone: _____ State: _____ Zip Code: _____
Work Phone: _____ Ext: _____ Cell Phone: _____
E-mail Address: _____

Do we have your permission to send you text messages? Yes No **Email messages?** Yes No

Spouse's Name: _____ Phone: _____
Parent's Name (If child): _____ Phone: _____
Employer: _____ Phone: _____

Whom may we contact in the case of an emergency?

Name: _____ Relationship: _____ Phone: _____

How did you hear about our office? Newspaper Yellow Pages Mailing Friend/Family _____
 Other (please specify) _____

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment for treatment. I consent, until revoked in writing, to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care: _____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed all answers. I certify this information is true and correct to the best of my knowledge. I will notify your office promptly of any changes in my status, insurance (if applicable) or any of the above information.

Health History Questionnaire

Your health history is very important to us. In order that we may provide you with the best possible dental services, please answer all questions as accurately as possible; incorrect information may compromise your treatment. This form is part of your dental treatment record and all information is confidential.

Reason for today's visit (please check all that apply)

Examination/Cleaning Cosmetic Pain/Swelling Broken Tooth/Filling TMJ
 Other _____ How long has this been a concern? _____

Dental History

Do you feel you have (please check all that apply)

Painful teeth Gum disease Bad breath Sensitive teeth Jaw problems Bleeding

Is there anything you would change about your smile? Yes No

If so, what? _____

Health History

Please list any **current major health problems:** _____

Have you had a physical exam in the last 2 years? Yes No

Physician's Name _____ Phone _____

Have you ever had a serious illness, operation, or been hospitalized? Yes No

If yes, please explain: _____

Have you ever had an allergic reaction to any of the following: Medication Food Latex

Name of Medication or Food: _____

Do you smoke or use tobacco? Yes No Are you pregnant or think you may be pregnant? Yes No

Please list current medications:

Signature of Patient or Guardian (if minor)

Date

Patient Insurance Information

Primary Insurance:

Policy Holder: _____ Policy Holder Phone: _____
Policy Holder Date of Birth: _____ Social Security #: _____
Policy Holder Employer: _____
Insurance Company: _____ Insurance Co. Phone: _____
Claim Group #: _____ Member/Plan ID#: _____

Secondary Insurance (if applicable):

Policy Holder: _____ Policy Holder Phone: _____
Policy Holder Date of Birth: _____ Social Security #: _____
Policy Holder Employer: _____
Insurance Company: _____ Insurance Co. Phone: _____
Claim Group #: _____ Member/Plan ID#: _____

I hereby instruct and direct the above Insurance Company(ies) to pay for services rendered by check payable and mailed to **All Smiles, 133 Circle Way, Lake Jackson, TX 77566**. If my current policy prohibits direct payment to the doctor, I hereby instruct and direct you to make the check payable to me and mail it to: _____

Payment should be for the professional benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.** A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated on this _____ day of _____, 20_____.

Signature of Primary Policy Holder or Claimant

Signature of Secondary Policy Holder

MUTUAL AGREEMENT - PLEASE READ AND SIGN IN BOX BELOW

The Dentist takes pride in being able to extend a greater degree of privacy than is required by law. Dentist agrees not to provide medical/dental information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Dentist will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others. In consideration for treatment and patient protection, if Patient prepares commentary for publication on web pages, blogs, and/or mass correspondence about Dentist, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Dentist for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Dentist's last date of service to Patient. As a matter of office policy, Dentist is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dentist's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Dentist-Patient relationship.

Patient and Dentist acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Dentist agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS _____ DAY OF _____, 20_____.

Signature of Patient or Guardian (if minor)

Peter Norris, DDS

PLEASE READ AND SIGN IN BOX BELOW

Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist’s advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary. The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist. If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective.

I understand that I am entering into a contractual relationship with Dr. Norris for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care, and may result in irreparable harm to a dental provider. As additional consideration for professional care provided to me by Dr. Norris, I, agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Dr. Norris.

Furthermore, should a dental malpractice case or cause of action be initiated or pursued, I agree to use expert witness(es) who practice primarily in the same specialty as Dr. Norris. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and /or code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this, Dr. Norris agrees to the same stipulations.

I acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Doctor’s reputation and business. Both Dr. Norris and I agree in the event of a breach to allow specific performance and/or injunctive relief.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling and discomfort after treatment
2. Infection in need of medication, follow-up procedures or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste
4. Damage to adjacent teeth, restorations or gums
5. Possible deterioration of your condition which may result in tooth loss
6. The need for replacement of restorations, implants or other appliances in the future
7. An altered bite in need of adjustment
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist
9. A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop
10. Jaw fracture
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Signature of Patient or Guardian (if minor)

Date