Patient Information

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)

E-Mail Address: _________________________ Gender: __________ Family Status: __________

Social Security #: _________________________ Birth Date: _______________________

Phone (Home): ________________ (Work): ________________ (Cell): ________________

Address: ____
Street Apt # City State Zip

Person to Contact in Case of Emergency_________________ Phone_____________________

Health Information

Date of Last Dental Visit: ______________ Reason for this visit: _________________________

Please check those that apply:

- ☐ AIDS
- ☐ Anemia
- ☐ Angina/Chest Pains
- ☐ Arthritis
- ☐ Artificial Joints (Please Clarify Below)
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Codeine Allergy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Facial Pain/Toothache
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack Date: ______________
- ☐ Heart Disease (Please Clarify Below)
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Orthodontic Treatment
- ☐ Pacemaker
- ☐ Partial/Denture
- ☐ Penicillin Allergy
- ☐ Pregnancy Due Date: ____________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Sleep Apnea/Snoring
- ☐ Smoking
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tooth Sensitivity
- ☐ TMJ Pain
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other Allergies: ________________ ________________
- ☐ Other Conditions: ________________

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you taking any medications? ☐ Yes ☐ No
  If yes, please list: ____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________ Phone: __________________
- Do you like your smile? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? : ________________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best time to call: ____________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ____ ____________

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ____________ ID #: ______________ Group #: ______________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ______________________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ____________ ID #: ______________ Group #: ______________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

Insurance Plan Name and Address: ____

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ______________

Signature of patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ______________

Signature of guarantor of payment/responsible party

HIPAA CONSENT FORM
West Houston Dental
12280 Westheimer Rd. Ste 400
Houston, TX 77077

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Patient/Guardian Signature: ____

Relationship to Patient: ____

Date: _____________________________