Summer Hill Dental

Matthew W. Bayless DDS, PC
19750 State Highway 46 W., Suite 105
Spring Branch, TX 78070

Thank you for visiting Summer Hill Dental. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____ (LAST) _____ (FIRST) _____ (MIDDLE INITIAL) _____ (NICKNAME)

Address _____ (STREET)

_____ (CITY) _____ (STATE) _____ (ZIP)

Employer _____ Driver's License # _____

Birthdate _____ ☐ Married ☐ Divorced ☐ Single

Phone: Home (___) _____ Social Security # _____

Work (___) _____ May we contact you at work? ☐ Yes ☐ No

Mobile(___) _____ ☐ Male ☐ Female

E-mail address _____

Emergency: Name _____ Phone (___) _____

Insurance ~ Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____ Group# _____

Insurance ~ Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____ Group # _____

MEDICAL INSURANCE CARRIER

Subscriber Name _____ Social Security # _____ Group# _____

Employer _____ Ins Co. _____ DOB _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Signature _____ **Date** _____

If Patient is under 18

Responsible Party _____ Relation to Patient _____

Address _____ (STREET)

_____ (CITY) _____ (STATE) _____ (ZIP)

Telephone (___) _____

Summer Hill Dental
Matthew W. Bayless, DDS
19750 SH 46 W #105, Spring Branch, TX, 78070
(830)438-2193-phone

How did you hear about us? _____

OCCUPATION_____

CHIEF CONCERN_____

HISTORY OF CHIEF CONCERN_____

_____

PREVIOUS DIAGNOSES_____

Smoke?____ Packs/day____ #years____ Drink coffee/cola?____ How much/day?____

Are you currently under medical care for any reasons? If yes, please explain:_____

_____

Please list all medical doctors that you currently see:_____

_____

Please list all medications that you are now taking:_____

_____

PAST MEDICAL HISTORY: (Please check ALL that apply) **Do You SNORE??** Yes / No

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other _____

Conditions

- ❑ Pre-med-Amoxicillin
- ❑ Pre-med-Clindamycin
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Congenital heart disease
- ❑ Cortisone medication
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV / Aids
- ❑ Heart Attack
- ❑ Head Injury
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Heart problem
- ❑ Heart Surgery
- ❑ Heart Valve Replace.
- ❑ HPV
- ❑ Hepatitis A / B / C
- ❑ High Blood Pressure
- ❑ High cholesterol
- ❑ Joint Replacement
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mental Disorder
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Sexually Transmitted Disease
- ❑ Height_____
  Weight_____
- ❑ Sinus Problems
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Stomach Problems
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Immune system disorder
- ❑ Mononucleosis (EBV)
- ❑ Frequent sore throats
- ❑ Tonsillitis
- ❑ Tonsillectomy
- ❑ Adenoidectomy
- ❑ Ear pain
- ❑ Hearing problem
- ❑ Headaches
- ❑ Head pain
- ❑ Neck pain
- ❑ Back pain
- ❑ Head, face, neck trauma
- ❑ Depression
- ❑ GERD
- ❑ Menopause
- ❑ Herpes
- ❑ Fibromyalgia
- ❑ Anxiety

If Female:

Y	N	
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant?
		If yes. # of weeks

Treatment Authorization

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. I authorize Dr. Bayless to correspond with my health care providers.

Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE _____ DATE _____

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Please Note:

Effective 12/1/2018

Appointments must be confirmed 2 days prior to appointment time or they will not be held. If a patient arrives for an unconfirmed appointment, it is possible they will have to wait or reschedule.

Summer Hill Dental Financial Policy

Thank you for choosing our office for your dental needs. Please understand that payment of your bill is considered part of you/your family's treatment. The following is our financial policy and all patients/guardians must sign this policy prior to seeing the doctor.

Because each financial situation is different, we will provide a written treatment plan with estimated costs for your review. **Payment for the patient portion of your treatment procedure will be required to schedule an appointment.** Please understand, regardless of insurance status, you will be responsible for the balance due on your account.

Your insurance is a contract between you and your insurance company. We are NOT a party to this contract; our relationship is with you. As a courtesy, we will file your claims promptly, but we cannot become involved with disputes between you and your insurance provider. The information provided us regarding your coverage and eligibility is not guaranteed and the actual coverage may be less than expected. Please note, you will be responsible for any balance after insurance pays. If payment is not received from your insurance company within 45 days, you will be asked to remit the full amount due and negotiate directly with them for your reimbursement.

We emphasize that our relationship is with you. **Our diagnosis of treatment is always in your best interest to become healthy and not based on what your insurance will or will not cover.** To assist you in receiving this care, we offer several payment options. You may choose to pay with cash, personal check, major credit card or Care Credit. If you request alternate arrangements, the details must be arranged in advance. If a collection agency must get involved, all agency fees will be the responsibility of the patient.

I authorize Dr. Matthew Bayless to release any information, including the diagnosis and records of any treatment or examination rendered to myself or family members during the period of such dental care to third party payors.

I authorize and request my insurance company to pay directly to Dr. Matthew Bayless, any benefits otherwise payable to me.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a **$50.00 per hour** fee for cancelled or missed appointments, (emergencies are an exception).

I have read the Summer Hill Dental Financial Policy, I understand and agree to the policy.

Signature_____ Date_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from those affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer