

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name _____
Last First MI (Preferred)
Birthdate _____ SS# _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N
Work Phone _____ Wireless Phone _____ Wireless Carrier _____
Email _____
Preferred contact method ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email
Preferred contact method for confirmations ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email
Preferred contact method for recall ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email
Student status if dependent over 19 (for ins) ☐ Nonstudent ☐ Fulltime ☐ Parttime
How did you hear about us?

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family ☐
Address _____
Address 2 _____
City _____ State _____ Zip _____
Home Phone _____

INSURANCE POLICY 1

Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____
Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____

Comments:

Signature: _____

FAMILY DENTAL CENTER OF EAST TEXAS
128 NACOGDOCHES ST
CENTER TX 75935

Date: _____

MEDICAL AND DENTAL HISTORY

Patient Name: _____				Date of Birth: _____			
Why are you here today? _____							
Are you having pain or discomfort at this time?				<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what type and where? _____							
Have you been under the care of a medical doctor during the past two years?				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Medical Doctor's Name: _____							
Are you now taking any medications, drugs, or pills?				<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please list medications? _____							
Are you aware of being allergic to or have you ever reacted badly to any medications or substance?							
<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please list: _____					
Do you use tobacco products (smoke or chew tobacco?)				<input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, how often and how much? _____				Do you use any recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you drink alcoholic beverages (beer, wine, whiskey, etc.)?				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Indicate which of the following you have had, or have. Check "Yes" OR "NO" for each item.							
Heart Disease or Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arteriosclerosis (hardening of arteries)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Angina Pectoris	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Sugar	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Congenital Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No		
HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold sores/Fever blisters/Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cosmetic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Allergies or Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A (infectious)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Artificial Joints (Hip, Knee, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B (serum)	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have or have you had any disease, or condition not listed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____							
For Women Only : Are you pregnant ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks? _____							
Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Are you taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No							
I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.							

X _____

Date: _____

HIPAA OMNIBUS RULE of
Family Dental Center of East Texas
**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** for 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: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

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

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

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

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email | |

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 these 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