PATIENT INFORMATION

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: _____

Email:

ADDRESS AND HOME PHONE Home Phone:

Address:

City: State: Zip:

PRIMARY CARE PHYSICIAN

PHONE

PHARMACY

PHONE

GUARANTOR

Name:

Cell Phone: Home Phone:

EMERGENCY CONTACT

NAME:

PHONE:

Relationship to patient

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 #: _____

_____

SIGNATURE

FAMILY DENTAL CENTER OF EAST TEXAS Date:_____
128 NACOGDOCHES ST
CENTER TX 75935

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

FAMILY DENTAL CENTER OF EAST TEXAS
128 Nacogdoches St.
Center Tx 75935

P:936.427.9070
F: 936.591.8191

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES 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:_____Patient Name: _____

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

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND 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:_____ Phone: _____

Name:_____ Phone: _____

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**

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.

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.**

A grace period of 15 minutes will be permitted for unforeseen delays a patient may encounter while travelling to the clinic location for their appointment. If a patient arrives more than 15 minutes late for their appointment, the patient will be rescheduled for a later date.

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

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

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 _____

COVID-19/Coronavirus Patient Notice and Acknowledgement Form

As you are aware, the Centers for Disease Control and Prevention has issued warnings and precautions to health care providers worldwide regarding coronavirus and COVID-19.

Here at Family Dental Center of East Texas we are taking every precaution to limit the exposure to any virus within our office community and we ask that you participate in the taking these precautions.

Please inform us immediately if you are currently experiencing a fever, cough, or difficulty breathing. By the placing of your initials here, you attest that you do not currently have a fever, cough, or difficulty breathing. (initial)_____

Please inform us immediately if you have travelled outside of the United States within the past thirty (30) days. By the placing of your initials here, you attest that you have not traveled outside the United States within the past thirty (30) days. (initial)_____

Please inform us immediately if you have had any recent travel outside of the state of Texas. By the placing of your initials here, you attest that you have not traveled outside the state of Texas within the past thirty (30) days. (initial)_____

If you have traveled outside of this state, please list the places to which you have traveled in the last thirty days, please list the places to which you have traveled.

(list)_____

Please inform us if you have had any contact or other exposure to a person diagnosed with, or subsequently diagnosed with, COVID-19. By the placing of your initials here, you attest that you have not had any contact or other exposure to a person diagnosed with, or subsequently diagnosed, with COVID-19. (initial)_____

In our efforts to protect the safety of the practice community as well as the community at large, it is the policy of Family Dental Center of East Texas to reschedule a patient's appointment for elective care if the patient is exhibiting symptoms of COVID-19, recently traveled abroad or to a high risk area, or was subject to a known exposure event.

In placing your signature below, you attest to the truth of your answers above and your understanding of Family Dental Center of East Texas office policy. We thank you and look forward to a return to normal practice.

_____ _____

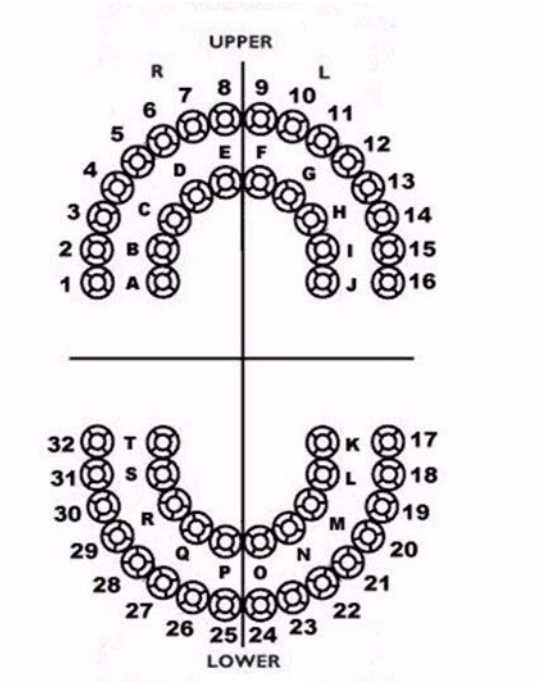
Print Name Date

_____

Signature of Patient or Legal Guardian

Treatment Consent for Children's Dental Center

I understand that my child will have dental procedures performed today. Please acknowledge that your Childs well-being and comfort is most important to us. The treatment may include the use of oral Anesthesia, nitrous oxide, and sedatives or radiographs that may be necessary to provide the best possible care for your child. In general terms, the procedure(s) may include, but are not limited to the following:



☐ **Preventive & Diagnostic Treatment:** Dental cleaning, Fluoride application, Sealant Application to dental fissures, and/or Radiography as necessary

☐ **Restorative Treatment:** Composite Filling(s), Stainless Steel Crown(s), and/or Direct or Indirect Pulpotomy(s)

☐ **Removal of Teeth:** Simple Extraction(s), Surgical Extraction(s), Root Tip Removal, Removal of Wisdom Teeth, and/or Impacted teeth

☐ **Orthodontic Treatment:** Bracket Bonding, Bracket Removal, Impressions, and/or Appliances

☐ **CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions discovered, but were not evident during examination. I authorize the doctor to use professional judgment to provide appropriate care.

☐ **DRUGS AND MEDICATIONS**
I understand that antibiotics, analgesics, anesthetics, and other medications can cause allergic Reactions, resulting in redness and swelling of tissues, itching pain, nausea and vomiting, or more severe allergic reactions. I have informed the doctor of any known allergies and medications that the Patient is currently taking.

☐ **RADIOGRAPHS**
In order to assess the patient's ability to tolerate and/or cooperate for dental procedures parents are not allowed in the treatment room during the initial patient assessment. The parent that desires to be in the treatment room with the patient will need to either wait in the treatment room or in the lobby until AFTER x-rays are taken. No one is allowed in the x-ray room with the patient during this time.

☐ **NITROUS OXIDE**
I understand nitrous oxide (laughing gas) provides relaxation to make it more comfortable for my child to receive the necessary dental care with less anxiety. He/She will awake, fully conscious, aware of his/her surroundings, and able to respond rationally. I have informed the doctor of my child's complete medical history, including any recent surgeries, illness, and changes in health history since his/her last visit.

☐ **LOCAL ANESTHETIC**
I understand there are risks of local anesthesia that may affect my child's body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, numbness, and/or tingling that may persist for several weeks, months, or rarely, permanent. I have informed the doctor of my child's complete medical history, including any recent surgeries, illness, and changes in health history since his/her last visit.

☐ **REMOVAL OF TEETH**
Alternative to tooth removal have been explained to me. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risks of removing teeth include, but are not limited to: pain, swelling, bleeding, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip or other facial areas, cheek, tongue, gums, and teeth. Such numbness may be temporary or permanent. Also, there is the possibility of a small root piece being left in the jaw where the risks of removing it outweigh the benefits. I understand that further care by a specialist or even hospitalization may be needed if complications arise during or after treatment, and that costs incurred are my responsibility.

FINANCIAL ARRANGEMENTS
I acknowledge that I am responsible of knowing what my insurance will cover. I understand the office has made every attempt to estimate what my treatment will cost and what insurance will pay including contacting them to confirm coverage and that I am responsible for any portion that is not covered by insurance.

INSURANCE PAYMENT AUTHORIZATION:
a. By signing below, I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has contractual agreements with my plan prohibiting all or portion of such charges to the extent permitted by law. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
b. I also hereby authorize the direct payment of dental benefits otherwise payable to me, directly to the below named dentist or the dental entity.

_____ _____
PATIENT NAME **DATE**

_____ _____
PARENT/GUARDIAN SIGNATURE **PROVIDER SIGNATURE**