PATIENT INFORMATION

Patient Name: _____Date:_____

How did you find out about our office? _____

Email Address:_____

Gender: ☐ M ☐ F Family Status: ☐ Single ☐ Married ☐ Other

Birth Date: _____/_____/_____ Social Security: _____-_____-_____

Address: _____

City: _____State:_____Zip:_____

Phone: (Home) _____ (Work)_____ (Cell)_____

Emergency Contact:_____ Cell:_____ Relationship:_____

FINANCIALLY RESPONSIBLE PARTY (If different from above)

Name: _____Relationship to patient: _____

Birth Date: _____/_____/_____ Social Security: _____-_____-_____

Address: (if different from above)_____

City: _____State:_____Zip:_____

Phone: (Home) _____ (Work)_____ (Cell)_____

INSURANCE INFORMATION

Name of Insured:_____ Insured Relation To Patient: _____

Address: (if different)_____ City: _____St:_____ Zip: _____

Insured's Social Security: _____ Birth Date: _____/_____/_____

Insured's Employer: _____ Insurance Company: _____ _____

Group Number: _____

Insurance Identification Number:_____ Insurance Phone Number_____

As a courtesy, we will file all dental claims within our office. All fees quoted will expire within 90 days and are subject to change. All quotes given are only estimates. Insurance companies do not guarantee payment and we will not know exact amounts due until your insurance company responds to the claim. **REGARDLESS OF WHAY YOUR INSURANCE PAYS, YOU ARE FULLY RESPONSIBLE FOR ANY BALANCES DUE.** Once payment is received an account statement will be sent.

I authorize my insurance company to make payments directly to Cross Timbers Dental on my behalf for treatment rendered. I fully understand that quoted costs are estimates only, and the patient portion may change if treatment changes or the insurance pays more or less than estimated.

Signature of Patient/Parent or Guardian:_____ Date: _____

Please sign or initial the following sections below

CONSENT FOR SERVICE AND FINANCIAL AGREEMENT

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment at the time of your treatment is considered a part of your commitment to our office. We ask that you read and sign this agreement prior to any treatment. **PAYMENT IS REQUIRED AT THE TIME OF TREATMENT.** We accept cash, checks, debit cards and all major credit cards. For extensive treatment, we offer payment plans using third party financing with prior credit approval.

Initial: _____

MISSED APPOINTMENTS

We will contact you with several reminders of your appointment time by mail, email and/or text messages. If you need to change or cancel your appointment, please notify us **48 hours** in advance so we can accommodate other patients. Please note there is a **$45.00** charge without 48 hours' notice.

Initial: _____

PATIENT CONSENT TO THE USE OF HEALTH INFORMATION

Cross Timbers Dental originates and maintains paper and/or electronic records describing your health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as a basis for planning your care and communication with other relevant health care providers. It is also a means by which a third-party can verify that conditions were present and services were provided competently.

You have the following rights and privileges:

- To review A *Notice of Information Practices & HIPAA* which is a more detailed description of the use and disclosure of health information prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.
- To revoke this consent in writing, except to the extent that the organization has already taken action.

Cross Timbers Dental has the following rights:

- To refuse treatment if the restrictions prevent Cross Timbers Dental from providing adequate care and are not required to agree to the restrictions requested.
- To change notices and practices. Should Cross Timbers Dental change their notice, they will send a copy of any revised notice to the address I've provided whether U.S. mail or, if I agree, email.

I consent to Cross Timbers Dental:

- To disclose necessary Information by any means including fax, email, telephone, voice, or correspondence to another entity for treatment and/or third party payment.
- Telephone voice mail, answering machines or e-mail for the purpose of leaving an appointment reminder or a message to include name and phone number to call.
- To communicate treatment plans and financial information verbally, by e-mail or in writing with my immediate family.

By signing below, I acknowledge responsibility and agree to the terms. I also consent to the Use of Health Information and have been offered a copy of the HIPAA rights and privileges.

_____ _____ _____

Signature of Patient, Parent or Guardian | Date | Relationship to Patient

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____What was this exam for? _____

Have you been hospitalized in the last 5 years? ☐ No ☐ Yes

If yes, reason: _____

Are you currently receiving care or have had a physical within the past 2 years? ☐ No ☐ Yes

If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

	No	Yes		No	Yes
Acid Reflux			Heart Stent When placed?		
Angranulocyctosis			Hepatitis, Any Form		
Anemia or Blood Disorder			H.I.V. Infection/AIDS or ARC		
Arthritis, Rheumatism or other inflammatory disease			Joint Replacement When placed?		
Asthma			Kidney Disease		
Abnormal Bleeding from a cut			Liver Disease (including Jaundice)		
Blood Disorder			Sore/Enlarged Lymph Nodes		
Cancer or Tumor			Osteoporosis		
Diabetes I or II			Pace Maker		
Emphysema or other Respiratory/Lung Illnesses			Previous Biopsies		
Epilepsy/Seizures			Psychosis		
Fainting or Dizzy Spells			Radiation or Chemo Treatment		
Glaucoma			Recurrent Illnesses		
Head Injury			Sinus Problems		
High Blood Pressure, Hypertension			Slow-Healing Mouth Sores		
Abnormal Heart or Previous Bacterial Endocarditis			Stomach Problems		
Congenital Heart Disease			Stroke		
Heart Valve (artificial) or Heart Transplant			Tuberculosis		
Heart Valve Dysfunction			Ulcers		
Heart Disease, Heart Attack, Heart Surgery			Unintentional Weight Loss/Gain		

Other conditions or surgeries not listed above?

Please explain:_____

Do you need to take an antibiotic before dental care? ☐ No ☐ Yes Reason: _____

Please list any medications you are currently taking and dosages:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Women: Are you pregnant? ☐ No ☐ Yes
If no, are you planning a pregnancy in the near future? ☐ No ☐ Yes
Are you a nursing mother? ☐ No ☐ Yes
Are you taking birth control pills? ☐ No ☐ Yes

Are you allergic or have you had a reaction to the following?

a. Local anesthetics …….. ☐ No ☐ Yes
b. Penicillin or other antibiotics …….. ☐ No ☐ Yes
c. Aspirin, Ibuprofen or Tylenol ……. ☐ No ☐ Yes
d. Codeine, Valium® or other sedatives…… ☐ No ☐ Yes
e. Latex …… ☐ No ☐ Yes
f. Metals ……... ☐ No ☐ Yes
g. Food Substances or Dyes ..... ☐ No ☐ Yes
h. Other (please specify) _____

Do you use tobacco? If yes, smoke or chew How much per day? For how long?	☐ No	☐ Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	☐ No	☐ Yes
Do you use any mood altering drugs other than those previously listed?	☐ No	☐ Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of changes in my health and medication.

_____ _____ _____
Patient / Legal Guardian (Print Name) Patient / Legal Guardian Signature Date