Patient Name_____ Date of Birth _____
If Patient is child, Parent's Name_____
Street Address_____ Male or Female
City _____ State____ Zip _____ Cell Phone (___)_____
Home Telephone (____)_____ Work Phone (____)_____
Name of Employer_____ Email Address _____
SS # of Patient _____ Driver's License # _____

Dental Insurance □Yes □ No:
Policy Holder's Name _____**Employer** _____
Ins Company _____ Phone # _____ Group # _____
Insured: SS#_____ **Date of Birth** _____

Whom may we contact in case of an emergency? _____
Phone# _____Relationship_____

How did you hear about our office? _____

PLEASE READ CAREFULLY:

I authorize the doctor to perform any and all forms of treatment that may be indicated in connection with the dental care of the patient above and to choose and employ such assistance as he sees it fit. I understand that prior to treatment; full explanation of the procedures(s) involved will be given by the doctor and/ or his staff. I agree to pay for all services rendered at the time of treatment unless prior arrangements have been made. I understand the total balance for all services is my responsibility, including any remaining after insurance co-payment. (A $5.00 billing fee will be applied to any remaining balance after 60 days from service date.) **We ask that you notify our office 48 hours in advance if circumstances require you to change your appointment.**

Signed _____ Date _____

Relationship to Patient _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Examination Questionnaire

Name:_____ Date:_____

1. What is the reason for today's visit? _____
2. Why did you leave your last dentist? _____
3. How long since your last dental exam? _____
4. Were x-rays of ALL teeth taken at that time? _____
5. What did you like the most about any former dentist? _____
6. What did you like the least? _____
7. Have you experienced any discomfort from your teeth or gums lately?____
8. Has the fear of pain kept you from regular dental visits? _____
9. Are you troubled by bad breath? _____
10. Do your gums bleed easily, feel tender or irritated? _____
11. Are your teeth sensitive to hot, cold, or sweets? _____
12. Would you like to retain your natural teeth as long as possible? _____
13. Are you aware of grinding or clenching your teeth? _____
14. Are you interested in cosmetic fillings in place of dark fillings? _____
15. If there was a simple, inexpensive way to whiten your teeth, would you be interested? _____
16. If you could wave a magic wand and change one thing about your smile, what would it be? _____
17. What do you expect of us as your dentist?_____
18. What could we do to make your dental visits more pleasant?

_____

Dossett Dental
4550 W. Eldorado Pkwy Ste. 107
McKinney, TX 75070

FINANCE POLICY FOR OUR DENTAL PATIENTS

It is our goal to provide the best possible dental care for you and at the same time avoid any confusion regarding our financial policy. We promise to provide you, in advance of treatment, with the amount of payment that will be required. This way you have the opportunity to discuss treatment alternatives or payment arrangements if finances are a concern.

REGARDING FINANCIAL ASSISTANCE

We do realize that, on occasion, financial circumstances can make payment difficult. If you have a financial concern, we ask that you speak with our financial manager. We accept MasterCard, Visa, American Express and Discover. We have also made it possible for patients to arrange for financial assistance.

REGARDING DENTAL INSURANCE

Our office accepts most IN and OUT of network insurance. Your insurance benefits are based upon a contract between your employer and the insurance company, not our office. ***THE INSURANCE COMPANY USUALLY ONLY PAY A PERCENTAGE OF THE FEE, WHICH VARIES FROM PLAN TO PLAN.*** It is not designed to pay the entire cost of your treatment, but to help cover a certain portion. A better term for dental insurance may be "dental assistance". Keep in mind that although an insurance company may state that their plan provides "100%" or "80%" coverage for certain service, they do not specify the fee **they allow** for these services. Your insurance company may explain to you that our fees are higher than their "usual and customary" fee. However, their fees are known to us and generally not the same charged in our office or in other offices. We are proud that our fees reflect the overall quality of the care and service that we provide.

FINANCIAL RESPONSIBILITY AGREEMENT

The agreement for treatment and payment is between the patient and our office. The charges, therefore, are your responsibility. In the event of non-payment, the patient agrees to pay all the costs of collection, including but not limited to attorney fees, court costs, collection agency fees, etc. If a check is dishonored or returned for any reason, you agree to cover any return check fees placed on this office. Your usage of a check for payment is your acceptance of this agreement and its terms. ***Please note that a $5.00 billing fee will be applied to any remaining balance after 60 days from service date.***

I have read and understood the financial policy of this practice and I agree its terms. I also understand and agree that such terms may be amended from time to time by the dental practice.

_____ _____

Patient/Responsible Party 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 / FACILITYS IN THE FUTURE.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

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

☐ First Name Only ☐ Proper Sir Name ☐ 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
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

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

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **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:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

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