



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 \_\_\_\_\_

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

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### **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 / FACILITIES 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: \_\_\_\_\_

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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"/> <b>Any of the Above</b>       |

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"/> <b>Any of the Above</b>       |

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"/> <b>Any of the Above</b>            |
| <input type="checkbox"/> Text Message  | <input type="checkbox"/> <b>None of the above</b> (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