Print Form Reset Form

Heart of Texas General Dentistry **Date_____**
William E. Privett D.D.S., F.A.G.D.

Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

ABOUT YOU

Name: _____ I prefer to be called_____ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Child Children: [ ] Yes [ ] No

Date of Birth: ____ ____ ____ Age: _____ S.S. #: _____ DL #:_____

Home Address:_____ Apt #_____City_____State____Zip_____

Home Phone: (_____) _____ Work: (_____) _____ Dept./Ext. _____

Cell: (_____) _____ E-mail Address: _____

Employer: _____ How long there? _____ Occupation: _____

Student Status (19 or older): [ ] Full-time [ ] Part-time Name of School: _____

Whom may we thank for referring you? _____ [ ] Yellow Pages [ ] Website:_____ [ ] Other

SPOUSE INFORMATION

Name: _____ Birth date:

Employer: _____ Work Phone: (_____) _____ Dept./Ext. _____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: _____ Date of Birth:____ ____ ____ Relation:_____

Billing Address: _____ Apt#_____ City_____State____Zip_____

Home Phone: (_____) _____ Work: (_____) _____ S.S. #: _____

Employer:_____ How long there? _____Occupation:_____

DENTAL INSURANCE INFORMATION

Primary Insurance
Insurance Co. Name: _____Group/Policy #: _____
Member I.D. #: _____Phone: (_____) _____
Insured's Name: _____ Insured's Birth date: ___ ___ ___ Relation: _____
Insured's Home Address:_____ Apt #_____City_____State____Zip_____
Insured's Social Security #: _____ Phone: (_____) _____ Insured's Employer: _____

Secondary Insurance (A filing fee of 3% will be assessed)
Insurance Co. Name: _____Group/Policy #: _____
Member I.D. #: _____Phone: (_____) _____
Insured's Name: _____ Insured's Birth date: ___ ___ ___ Relation: _____
Insured's Home Address:_____ Apt #_____City_____State____Zip_____
Insured's Social Security #: _____ Phone: (_____) _____ Insured's Employer: _____

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MEDICAL HISTORY INFORMATION

Name of Physician: _____ Date of last visit: Phone:

Do you currently have or have you ever had any of the following? Please check those that apply:

[ ] Artificial Bone/Joints*	[ ] Stroke	[ ] Arthritis	[ ] Thyroid Problems
[ ] Artificial Heart Valves*	[ ] Angina	[ ] Asthma	[ ] Osteoporosis
[ ] Congenital Heart Defect*	[ ] Anemia	[ ] Respiratory Problems	[ ] Glaucoma
[ ] Heart Murmur*	[ ] Cancer	[ ] Breathing Problems	[ ] Yellow Jaundice
[ ] Mitral Valve Prolapse*	[ ] Tumor	[ ] Frequent Cough	[ ] Stomach Ulcers
[ ] Abnormal Heart Condition*	[ ] Chemotherapy	[ ] Fainting or Dizziness	[ ] Fever Blisters
[ ] Surgical Shunt*	[ ] Radiation Treatment	[ ] Epilepsy or Seizures	[ ] Chemical Dependency
[ ] HIV+* [ ] AIDS*	[ ] STD's	[ ] Diabetes	[ ] Mental Disorders
[ ] Heart Pace Maker	[ ] Tuberculosis (TB)	[ ] Liver Disorder	[ ] Rheumatic Fever
[ ] High Blood Pressure	[ ] Hepatitis [ ] **A** [ ] **B** [ ] **C**	[ ] Kidney Problems	[ ] Sickle Cell Disease

***** This condition may require antibiotic premedication for certain dental procedures.

YES **NO**

[ ] [ ] Do you have any health problems that were not listed above or need further clarification?
If yes, please explain: _____

[ ] [ ] Are you currently under the care of a physician?
If yes, please explain:_____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, please explain: _____

[ ] [ ] Do you use tobacco products?

[ ] [ ] Are you currently taking or have taken **Fosomax** (Alendronate Sodium) or other bisphosphonates in the past?

[ ] [ ] Do you take, or have you taken Phen-fen or Redux?

[ ] [ ] **Do you take a daily aspirin regimen or any other type of anticoagulants/blood thinners?**
If yes, please list: _____

[ ] [ ] Are you currently taking any medications or herbal supplements?
If yes, please list:

_____

[ ] [ ] Are you **allergic** to any medications or substances? If yes, please check box below:
[ ] Aspirin [ ] Penicillin/Amoxicillin [ ] Codeine [ ] Erythromycin [ ] Local Anesthetic [ ] Latex
[ ] Other_____

WOMEN (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

What is your chief concern about your dental health/condition? _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X _____ _____
Signature of patient or responsible party Date

APPOINTMENTS

When you make an appointment with us please be on time since we have reserved that time slot for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us with at least **2 working days advanced notification** so that we may use that time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

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FINANCIAL POLICY

Payment in full is due on the day of treatment. Any discrepancies with insurance eligibility and/or coverage will be the patient's responsibility. The insurance plan is YOURS and our office has no leverage for payments; you are ultimately responsible for all payments when service is rendered.

Payment Options
1. For your convenience we accept Cash, Check, Visa, MasterCard, Discover & American Express.
2. We also offer short and long-term financing options through Care Credit®, if eligible.

For Patients with Dental Insurance
Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you during your appointment. Please ask us if you have any questions.

Fees
• Returned checks are subject to a $35 accounting fee.

HIPPA PRIVACY PRACTICES CONSENT

We are required by law and regulation to protect the privacy of your medical and dental information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect. If you would like to read the HIPPA Notice in detail, please refer to the binder in the waiting room. A copy will be furnished upon request.

_____ X_____ _____
Printed Name Signature of patient or responsible party Date

AUTHORIZATION AND CONSENT

General Consent to Treatment
I agree and consent to a dental examination and x-rays when needed. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information
I authorize Dr. Privett to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits
I authorize and request my insurance company to pay my benefits directly to Dr. William E. Privett D.D.S., F.A.G.D.

Photography Release
I authorize Dr. Privett to take photographs of me if needed to help me better understand my current dental condition and possible treatment options. I also authorize him to provide these photographs to our dental labs for optimal quality purposes in restorative procedures.

I understand and will comply with office **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.
I authorize **Photographs** to be taken of me if needed and provided to dental labs.

X _____ _____
Signature of patient or responsible party Date