FAIRBANKS
DENTAL ASSOCIATES

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____NICKNAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____

SEX: M F MARITAL STATUS: M S D W SS . #:_____DOB:_____

CELL PHONE:_____ HOME PHONE(landline):_____E-MAIL:_____

EMPLOYER & OCCUPATION: _____ WORK PHONE:_____

DENTAL INSURANCE NAME:_____CUSTOMER SERVICE PHONE #:_____

SUBSCRIBER'S NAME: _____SUBSCRIBER'S DOB:_____ RELATIONSHIP TO PATIENT:_____

SUBSCRIBER ID/SS#:_____ GROUP/PLAN#_____

RESPONSIBLE PARTY INFORMATION (who is responsible for the bill) IF SAME AS PATIENT, PLEASE CHECK HERE: _____

FIRST NAME:_____ LAST NAME:_____ DOB:_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ WORK PHONE: _____ HOME: _____

SOC. SEC. #:_____ RELATIONSHIP TO PATIENT:_____

IN CASE OF EMERGENCY PLEASE NOTIFY:_____RELATIONSHIP TO PATIENT:_____

EMERGENCY CONTACT CELL PHONE:_____ WORK PHONE:_____

HOW DID YOU HEAR ABOUT OUR OFFICE?:_____

MEDICAL INFORMATION

In order to provide comprehensive dental treatment, we need to be more familiar with your general health history, some conditions could affect your dental health, thus altering your treatment needs. Please take a moment to respond to the following items.

NAME OF FAMILY PHYSICIAN: _____ PHONE NUMBER: _____

Current Tobacco Product use? Yes__No___Past Tobacco use? Yes___No___ If yes,what products do/did you use?_____

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING**?** ***(please place a checkmark for each condition that applies)***

____ Blood disorders	____ Stroke	____ Diabetes	____ Fainting
____ Heart disease	____ Lung disease	____ Epilepsy	____ Arthritis
____ Heart attack	____ Tuberculosis	____ Anemia	____ Seasonal Allergies
____ Heart murmur	____ Asthma	____ Tumor history	____ Chronic Sinus problems
____ Rheumatic fever	____ Liver disease	____ Artificial joints	____ Glaucoma
____ Chest pains (Angina)	____ Hepatitis	____ High blood pressure	____ Herpes Simplex Virus
____ AIDS / HIV+	____ Kidney disease	____ Low blood pressure	____ Human Papilloma Virus
____ Padgett's Disease	____ Multiple Myeloma	____ Thyroid Issues	____ Gum Disease, did you receive treatment?_____
____ Systemic Lupus	____ Acid Reflux	____ Eating Disorder	____ Osteoporosis
____ Sleep Apnea	____ Cancer	____ Psychiatric treatment	____ Bisphosphonate Drug Use (Osteoporosis Drug)

*** NONE OF THE ABOVE CONDITIONS APPLY TO ME _____

OTHER SYSTEMIC CONDITIONS/ Please explain any checked conditions: _____ _____ _____ _____

MEDICATION ALLERGIES (please check all that apply) No Known Drug Allergies ____ Amoxicillin_____ Aspirin____ Clindamycin____

Codeine____ Erythromycin____ Ibuprofen____ Penicillin____ Other:_____

ARE YOU TAKING ANY DRUGS, MEDICATION, OR PILLS? Y N Please list with reason for each medication

_____

_____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY? Y N EXPLAIN: _____

WOMEN: ARE YOU PREGNANT? Y N DUE DATE: _____ **BP**_____**P**_____

DENTAL HISTORY

NAME OF PREVIOUS DENTIST:_____Phone_____

WHEN WAS YOUR LAST DENTAL VISIT AND WHAT WAS DONE ? _____

HOW OFTEN DO YOU BRUSH ?_____ AND FLOSS ?_____DO YOU USE AN ELECTRIC TOOTHBRUSH? Y___ N___

ON A SCALE OF 1-10 (1=not important, 10=extremely) HOW IMPORTANT ARE YOUR TEETH TO YOU?_____

In your own words, please explain to us what your chief complaint of your dental health is. Also, is there anything regarding your past dental care or experiences you would like for us to know before beginning any treatment?

_____

_____

Please check YES or NO for each question

Yes___ No___ DO YOU HAVE A SPECIFIC PROBLEM WHICH NEEDS IMMEDIATE ATTENTION? _____

Yes___ No___ ARE YOU APPREHENSIVE ABOUT DENTAL CARE? PLEASE EXPLAIN: _____

Yes___ No___ HAVE THERE EVER BEEN ANY COMPLICATIONS WITH PREVIOUS DENTAL TREATMENT?

Yes___ No___ DOES YOUR JAW EVER CLICK OR POP WHILE OPENING OR CLOSING?

Yes___ No___ DOES YOUR JAW EVER CAUSE YOU ANY PAIN WHILE OPENING, CLOSING, OR ANY OTHER TIME?

Yes___ No___ DO YOU SUFFER FROM FREQUENT HEADACHES? RINGING IN YOUR EARS?

Yes___ No___ HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?

Yes___ No___ HAVE YOU EVER HAD PROLONGED OR UNUSUAL BLEEDING?

Yes___ No___ HAVE YOU EVER HAD COMPLICATIONS OR ILLNESS FOLLOWING DENTAL TREATMENT?

Yes___ No___ HAVE YOU EVER HAD AN INJURY OR TRAUMA TO YOUR FACE OR JAW?

Yes___ No___ ARE YOU DISSATISFIED WITH YOUR TEETH AND THEIR APPEARANCE? PLEASE EXPLAIN:

_____

Yes___ No___ ARE YOU CONCERNED ABOUT THE FINANCES REQUIRED TO RETURN YOUR MOUTH TO EXCELLENT DENTAL HEALTH?

TREATMENT AUTHORIZATION AND ACKNOWLEDGMENT

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT NAMED ABOVE, FOR THE DIAGNOSIS OF DENTAL DISEASE, DEFORMITY, OR TREATMENT OF A DENTAL EMERGENCY. THESE PROCEDURES MAY INCLUDE RADIOGRAPHY, MODELS, AND INTRAORAL EXAMINATION. IN THE CASE OF DENTAL EMERGENCY, I CONSENT TO TREATMENT AS DEEMED NECESSARY BY THE DOCTOR, UNDERSTANDING THAT THE PROCEDURES WILL BE EXPLAINED IN ADVANCE. I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT ANY PROPOSED TREATMENTWILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE TREATMENT RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, will be used as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY AUTHORIZING PAYMENT DIRECTLY TO FAIRBANKS DENTAL ASSOCIATES OTHERWISE PAYABLE TO MYSELF. This payment will not exceed my indebtedness to the above mentioned assignee.

A photocopy of the Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

THE UNDERSIGNED SHALL ASSUME ALL RESPONSIBILITY FOR ALL COLLECTION AGENCY COSTS AND OTHER RELATED COSTS INCLUDING ATTORNEY FEES INCURRED WHILE COLLECTING THE AMOUNT DUE.

PATIENT/RESPONSIBLE PARTY SIGNATURE_____DATE_____

DOCTOR SIGNATURE _____DATE_____

Fairbanks Dental Associates

Financial Policy

Payment is expected on the day that service is rendered. If you are a patient with Dental Insurance Benefits we will, as a courtesy to you, file your dental claim and allow up to 45 days for payment. If you have a secondary policy, we will submit claims on your behalf, but payment will go directly to you. Any balance following receipt of the primary insurance has to be paid in full prior to us submitting to your secondary plan.

Please be advised that dental insurance only pays a part of your treatment. Deductibles, co-pays, and usual, customary, and reasonable limitations reduce benefits. You are responsible for all portions not covered by your benefit plan. Based on the information that you provided us, we will try to estimate what your benefit plan will pay. **However, you are ultimately responsible for all incurred charges.** Payment arrangements must be made prior to scheduling your treatment. **If there are any changes to your benefit plan, it is your responsibility to inform the office a minimum of 48 hours prior to your appointment so that we can verify your new benefits.**

We accept Cash, Personal Checks (not third party checks), VISA, MasterCard, Discover and we will assist you with payment plan options through CareCredit or Cherry. There will be a $25.00 fee assessed for all returned checks for insufficient funds.

Minors, children under the age of 18, are to be accompanied by a parent or legal guardian and that person will be financially responsible for the child.

Appointment Policy: We kindly request a minimum of **two (2) business day's (Monday-Thursday)** notice to change appointments. Patient's that fail to provide this notice, or, who do not show up for an appointment will be charged a fee of **$50.00** for each hour scheduled. Appointments scheduled for **90 minutes or longer will require a 50% non-refundable deposit to reserve the appointment**. This deposit will be applied to your co-payment. Broken appointments or failure to provide proper notice of appointment changes will result in the forfeiture of your deposit.

* I have read and understand the above policies.

Patient Name(print):_____**Signature:**_____**Date:**_____
(Patient or Guardian)

HIPAA Policy, Texas SB-300 and Consent

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Patient Communications: With this consent I hereby give Fairbanks Dental Associates permission to contact me via US Postal service, e-mail and telephone (home/cell/work and permission to leave a message on voice mail or in person) in reference to any items that assist the practice in carrying out TPO (Treatment, Payment and Healthcare Operations) such as appointment reminders, insurance items, statements, marketing material and any calls pertaining to my clinical care.

Notice of Privacy Practices: You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this Consent. We encourage you to read it carefully before signing the Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including and revisions of our Notice, at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving this office written notice of your revocation. Please understand that revocation of the Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat or continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the content of this Consent form and your Notice of Privacy Practices, I understand that, by signing the Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare options.

Signature:_____**Date:**_____
Patient or Guardian

Fairbanks Dental Associates may discuss my finances, clinical or emergency care with the following person(s):

Name_____Relationship_____