Patient Information

Patient Name: ____ Date: __________

Last, First MI (Preferred Name)

☐ male ☐ female ☐ single ☐ married ☐ child ☐ other

Social Security____________________ Birth Date _____/_____/_______ State ID/TXDL#______________

Phone (Home): ____________ (Work)____________ Ext:______ (Cell)____________ (Preferred#)____________

Email address: ____.

Mailing Address:____

Street Apartment #

____

City State Zip Code

Health History

Have you ever had any of the following? Please check those that apply:

☐ Heart Attack _______
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Heart Surgery______
☐ Artificial Heart Valve
☐ Pacemaker
☐ Artificial Joints
  ☐ Knee/Hip
  ☐ Other __________
☐ Diabetes
☐ Kidney Disease
☐ Kidney Transplant
☐ Immunosuppressant Drugs
☐ Immune Deficiencies
☐ HIV/AIDS
☐ Rheumatism/Arthritis
☐ High Blood Pressure
☐ Stroke
☐ Glaucoma
☐ Tuberculosis
☐ Sleep Apnea

☐Cancer____________
  ☐ Radiation Treatment
  ☐ Chemotherapy
  ☐ Surgery__________
☐ Benign Growths_____
☐ Excessive Bleeding
☐ Hemophilia
☐ Liver Disease
☐ Hepatitis
  ☐ Hep A/B
  ☐ Hep C
☐ Jaundice
☐ Anemia
☐ Hyperthyroid
☐ Low Thyroid
☐ COPD
☐ Emphysema
☐ Asthma
☐ Sinus Problems
☐ Seasonal Allergies
☐ Seizures/Epilepsy
☐ Excessive Daytime Sleepiness

☐ Depression
☐ Anxiety
☐ Mental Disorders
  ☐ ADD / ADHD
  ☐ Other________
☐ Stomach Problems
  ☐ GERD
  ☐ Other________
☐ Ulcers
☐ Intestinal Disorders
☐ Alzheimer's
☐ Parkinson's
☐ Venereal Disease
☐ Fainting
☐ Pregnancy -currently
  DUE DATE________
☐ Hospitalized
  ____
☐ Bisphosphonate class Of medications
☐ OTHER MEDICAL CONDITIONS:_____

DRUG ALLERGIES
☐ Penicillin Allergy
☐ Clindamycin Allergy
☐ Erythromycin Allergy
☐ Tetracycline Allergy
☐ Codeine Allergy
☐ Hydrocodone Allergy
☐ Aspirin Allergy
☐ Ibuprofen Allergy
☐ Anesthetic Allergy
  Type ___________

OTHER ALLERGIES
☐ Latex
☐ Adhesives
☐ Acrylics
☐ Metals
☐ Black Rubber
☐ Food Allergies
☐ Other

Please list the medications you take:

_____________________. _____________________.
_____________________. _____________________.
_____________________. _____________________.
_____________________. _____________________.

Your Weight_____lbs
Your Height________

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____

Name of Physician: ______________________________________ Phone: ______________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I consent to treatment by the doctor and her staff as deemed necessary and appropriate.

______________________________________ Date: ______________
Signature of patient, parent or guardian

______________________________________ Date: ______________
Signature of doctor reviewing medical history

Dental History

Primary Reason for appointment:

☐Comprehensive Exam ☐Cosmetic Dentistry/Esthetic Consultation ☐Invisalign Consultation ☐Emergency

Do you have a specific dental problem you would like addressed?

☐ yes Please describe:____

☐ no

When was your last check up and cleaning? ______/______/________

How often do you brush? _______________

How often do you floss? _______________

Are your teeth Sensitive to: ☐Cold ☐Hot ☐Sweet ☐Biting/Chewing ☐Touch

Do your gums bleed? ☐yes ☐no

Do you clench or grind your teeth? ☐yes ☐no

Have you noticed cracks in your teeth? ☐yes ☐no

Do you have clicking or popping in the jaw joint ☐yes ☐no

Do you have discomfort in the jaw joint ☐yes ☐no

Do you have any sores, ulcers or growths in your mouth ☐yes ☐no

Have you ever had: ☐Scaling and Root Planing ☐TMJ therapy/surgery ☐Braces ☐Gum Surgery

Do you think you have gum disease? ☐yes ☐no

Do you think you have cavities? ☐yes ☐no

Do you Smoke or chew tobacco products? ☐yes ☐no If yes, How much/how long? #Cigs/Packs______/day/_____yrs

Do you consume alcoholic beverages? ☐yes ☐no If yes, ☐rarely ☐less than 2/day ☐more than 2/day

Do you use recreational drugs? ☐yes ☐no If yes, what type________________________________ ______

Are you pleased with the appearance of your teeth? ☐yes ☐no If no, please describe_________________________

Are you interested in improving your smile? ☐yes ☐no

Would you like whiter teeth? ☐yes ☐no

Describe any other changes you would like in the appearance of your teeth: _____________________________________

____

Have your past dental experiences always been positive? ☐yes ☐no If no, please describe_______________________

Do you have severe fear of dental treatment? ☐yes ☐no

Are you interested in some type of sedation? ☐yes ☐no

If yes: ☐nitrous sedation ☐oral conscious sedation

Photographic Release

In our office we like to photograph our patients for aid in determining their problems and to help come up with perfect treatment options for them. With these photographs, we can recreate your smile on the computer so that you can see the final results and approve of them before we start any procedure.

Our Doctors also use the photographs with the patient's permission to teach dentist form all over the world how we create beautiful smiles for our patients. They also plan to use the photographs to give lectures through the country on the latest advances of dental technology.

We are very proud of the work we have done and only use our own patients in our marketing and advertising. All of the portraits in our office, on our web site www.KatyOaksDental.com , and in our ads are our own patients and photography.

Authorization and release

I____________________________, hereby authorize Katy Oaks Dental and its staff to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides and/or videos are used in any publication or as part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature: ____________________________________

Date: ____

Who may we thank for referring you? _____________________________________

- Katy Oaks Sign
- Insurance Web page
- Katy Oaks Dental Website
- Neighborhood Newsletter
- Newspaper
- Community Impact News
- Other:____________________________

Financial Policy

PAYMENT IS EXPECTED AT THE TIME OF SERVICE
PAYMENT MAY BE IN THE FORM OF CHECK, CASH, CREDIT CARD, OR EXPECTED INSURANCE BENEFITS

Please read and initial:

_____ Initial — As a courtesy, we will file your insurance for you and allow 30 days for insurance payment on your account. On the day of service we will collect your approximate co-pay for the services rendered. Any balance left on the account after insurance payment is received is the responsibility of the patient or financial guarantor and you will receive a bill for any remaining balance. To keep your account in good standing, please remit payment by the due date on the statement.

_____ Initial — Once the insurance company has made payment on all outstanding claims for all members on the account, if there is a credit remaining on the account, it can be refunded to you upon your request or you may choose to leave it on the account against future treatment.

_____ Initial — A missed appointment or late cancellation fee of $45 will be assessed for less than 24hrs notice. This fee can be waived 1 time for emergencies only and by request.

By signing below I state that I have read, understood and agree to the above financial policy.

I also understand that I or my guarantor will be ultimately financially responsible for any balances on my account.

Patient/Parent or Guardian Signature: ______________________________ Date____/_____/_____

State ID/TXDL# :____________________

Guarantor Information

Responsible Party / Insurance Information

Name of Guarantor/Insured :____________________,____________________ (Last, First, MI, (preferred))

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ____________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________

Social Security #: ______________________ Birth Date: ____/____/______

Phone (Home): ______________ (Work): ______________ Ext: _____ (Cell#): ________________

Email address ______________________________

Address: ____ (Street, Apartment #)

____ (City, State, Zip Code)

Employer Name: ________________________ Occupation: ____________________

Address: ____ (Street, City, State Zip Code, Phone)

Insurance Plan Name ____

Insurance Address:____ (Street, City, State Zip Code)

Insurance Telephone # (_____) ________________

Group ID#________________ Member ID#________________

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*** name of Patient

______________________________ Please ***sign*** for Patient / Guardian of Patient

______________________________ Legal Representative / Guardian

______________________________ Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ______________________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ 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
- ☐ Email Confirmation (not encrypted)
- ☐ **Any of the Above**

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

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Email Confirmation (not encrypted)
- ☐ **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 (opt out)
- ☐ Email (not encrypted)
- ☐ **Any of the Above**
- ☐ **None of the above**

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

HIPAA made EASY™
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