

Date: _____

DOB: _____



Patient Name: _____

Names of Legal Guardians (if applicable): _____

Male: _____ Female: _____ Age: _____

Mailing Address: _____ City/State/: _____ Zip: _____

Physical Address: _____ City/State/: _____ Zip: _____

ZIP: _____ E-mail: _____ Marital Status: _____

Home #: _____ Cell #: _____ SS#: _____

How did you hear about us? _____

Emergency Contact: _____ Phone #: _____

Insurance: Dental

Medical (Please Complete Thoroughly)

Insurance Company: _____

Insurance Company: _____

Employer: _____

Employer: _____

Insurance Address: _____

Insurance Address: _____

Insurance Phone#: _____

Insurance Phone#: _____

Subscriber Name: _____

Subscriber Name: _____

Subscriber DOB: _____ ID #: _____

Subscriber DOB: _____ ID #: _____

SS #: _____ Group #: _____

SS #: _____ Group #: _____

Guarantor (person responsible for paying): _____ Relationship to Guarantor: _____

Address: _____ City/State: _____

ZIP: _____ Home #: _____ SS #: _____

I AGREE TO PAY THE TOTAL AMOUNT DUE TO THE DOCTOR FOR SERVICES RENDERED AT MY REQUEST AND PERMIT THIS OFFICE TO SUBMIT INSURANCE CLAIMS ON MY BEHALF.

After you have finished completing this, please bring it up to the front desk along with a copy of your current Dental/Medical insurance cards, and a current Driver License.

Signature: _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

IN OFFICE USE ONLY

- ☐ Copy of Dental Insurance Card
☐ Copy of Drivers License

- ☐ Copy of Medical Insurance Card
☐ Information Verified

Checked In Initials _____

DENTAL/MEDICAL HISTORY



Patient Name: _____ DOB: _____

MEDICAL HISTORY

Physician's Name: _____

Pharmacy used: _____

Are you currently under the care of a physician or specialist? _____

Have you had a serious illness, operation, or been hospitalized in the past 2 years: _____

If you answered yes to the above questions, please explain: _____

Please list prescription medications, vitamins, or dietary supplements you are currently taking:

(please include dosage and frequency) _____

Please check (✓) if you currently have or have had any of the following diseases or disorders:

- | | |
|--|--|
| ☐ Anemia | ☐ Heart Murmur |
| ☐ Angina (chest pains) | ☐ Hepatitis or Liver Disease |
| ☐ Arthritis/Rheumatism | ☐ High Blood Pressure |
| ☐ Artificial Heart Valves | ☐ HIV/AIDS |
| ☐ Artificial Joints | ☐ Kidney Disease |
| ☐ Asthma | ☐ Low Blood Pressure |
| ☐ Autoimmune Disorder | ☐ Mitral Valve Prolapse |
| ☐ Blood Disease/Bleeding Disorder | ☐ Osteoporosis |
| ☐ Cancer | ☐ Pacemaker |
| ☐ Cardiovascular Disease | ☐ Radiation Treatment |
| ☐ Street/Recreational Drugs | ☐ Respiratory Disease |
| ☐ Chemotherapy | ☐ Rheumatic Fever |
| ☐ Congenital Heart Disease | ☐ Stroke |
| ☐ Diabetes | ☐ Thyroid Problems |
| ☐ Epilepsy | ☐ Tobacco Use - Explain _____ |
| ☐ Fainting | ☐ Tuberculosis |
| ☐ Gastrointestinal Disease | ☐ Ulcers |
| ☐ Headaches | ☐ Venereal Disease |
| ☐ Insulin | ☐ Immunosuppression |
| | ☐ Contact Lenses |
| | ☐ None Apply |

Do you have a disease, condition, or problem not listed above? Please explain: _____

Do you have a medical condition that requires an antibiotic before dental treatment? _____

Have you taken/are you currently taking Fosamax, bisphosphonates, or any other drug for osteoporosis? _____

Are you currently taking blood thinners? _____

ALLERGIES

Please check (✓) if you have had a reaction to any of the following:

- | | |
|---|---|
| ☐ Latex | ☐ Local Anesthetics |
| ☐ Penicillin/Amoxicillin | ☐ Barbiturates, Sedatives, or Sleeping Pills |
| ☐ Sulfa Drugs | ☐ Codeine |
| ☐ Metals | ☐ Aspirin |
| ☐ Other: _____ | ☐ None |

DENTAL HISTORY

Reason for Today's Visit: _____

Do you like your smile? ☐ YES ☐ NO

Have you ever wanted to whiten your smile? ☐ YES ☐ NO

Do you use an electric toothbrush? ☐ YES ☐ NO

Date of Last Dental Visit: _____

Please check (✓) if you have or have had any of the following:

- ☐ Bleeding gums
- ☐ History of periodontal (gum) treatment
- ☐ History of mouth sores
- ☐ History of orthodontics (braces)
- ☐ Sensitivity to hot, cold, or sweets
- ☐ Headaches or neck pain
- ☐ Serious injury to head or mouth
- ☐ Clicking, popping, or discomfort of jaw
- ☐ Grinding or clenching of teeth
- ☐ Dentures or partials
- ☐ Missing Teeth

WOMEN ONLY

Are you Pregnant: _____ Nursing: _____ Taking oral contraceptives: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I have a change in health.

Patient Signature: _____ Date: _____

HIPAA

COMPLIANCE PATIENT CONSENT



Our Notice of Privacy Practice provides information about how we may use or disclose protected health information.

The notice contains a patient's right section describing your right under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so you will be notified at your next visit to update your signature/ date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will the cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you regarding your appointment?	YES	NO
May we send e statements in regards to your account?	YES	NO
May we leave a message on your answering machine or voicemail?	YES	NO
May we discuss your medical / dental condition with anyone other than yourself?	YES	NO
May we discuss your financial / billing information with anyone other than yourself?	YES	NO

Protecting the privacy of our patients is crucial; therefore, we ask that anyone accompanying a patient remain in the waiting area.

If **YES**, please name the members allowed:

This consent was signed by: *(please print name)* _____

Signature: _____ Date: _____

Witness: _____ Date: _____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION



Patient's Name: _____

Date of birth: _____ SSN: _____

Previous Name: _____

Doctor's Name _____

Practice Name: _____

I request and authorize the above listed doctor and practice to release health care information of the patient named above.

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

Or _____ All health care information

Or _____ Other: _____

THIS AUTHORIZATION EXPIRES ON _____ or _____ DAYS AFTER
THE DATE IT IS SIGNED; or WHEN THE FOLLOWING EVENT OCCURS _____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or
- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

Signature of patient or patient's authorized representative

Date signed

Relationship or status if signed by parent, legal guardian, personal representative, etc.



FINANCIAL AGREEMENT

Full payment is required at the time of service. Payment plan options are available such as Care Credit, Lending Point, and financing through Amarillo National Bank. By signing this form, you accept responsibility for all fees and services rendered, whether or not paid by insurance. The patient/guardian is responsible for all charges not covered by insurance. Any account with a pending balance will not be scheduled until balance is paid.

Initials: _____

INSURANCE

We are happy to file insurance claims as long as your insurance can be verified. If we are unable to verify your insurance with the information you provided, you will be responsible for full payment. You will be provided with an estimate of your insurance coverage and the amount you are responsible for. We have no control over insurance carriers; therefore, we cannot guarantee that this estimation is correct. Because dental insurance is a contract between the patient and the insurance carrier, the patient/guardian is responsible for all charges, regardless of insurance benefits. If we do not receive insurance payment within 5 weeks of treatment, patient/guardian will be expected to pay for all dental services. In the event of duplicate payment, you will be reimbursed. By signing this form, you understand that you are responsible for all fees associated with services rendered by Full Smile Dental.

Initials: _____

OUT OF NETWORK INSURANCE PLANS

It is the responsibility of patient/guardian to know if their insurance is in network with the Lubbock Dental Specialists office in which they are being seen for treatment. In the event that a patient's insurance is out-of-network, we will gladly file an insurance claim; however, the patient/guardian is responsible for all charges estimated to not be covered by insurance before they leave the office.

Initials: _____

NO-SHOW POLICY

When our office books your appointment, we are setting aside a dedicated time slot just for you. *If you must reschedule your appointment, please notify the office within 48 hours of your scheduled appointment time.* Lubbock Dental Specialists will charge a **NO SHOW** fee of \$50 if you fail to appear to any of your scheduled appointments. Any patient that is more than 10 minutes late to their appointment may be asked to reschedule.

Initials: _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

Patient/Guardian Signature: _____

Date: _____