(PLEASE PRINT)

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Alt. Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	How often do you floss? _____		
			Lip or cheek biting	☐ Yes	☐ No			
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____		

Dental Registration and History

Health History

Physician's Name _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with			Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
extractions or surgery	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head		
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			
Do you wear contact lenses?	☐ Yes	☐ No						

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ Aspirin	☐ Local Anesthetic
☐ Barbiturates (Sleeping pills)	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Iodine	☐ Other _____
☐ Latex	_____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature _____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature _____ Date_____

Forever Teeth P.L.L.C. 1305 FM 51, Suite 100, Decatur, TX 76234

(940) 626-4441 FAX (940) 626-4304

Acknowledgement of Receipt

Notice of Privacy Practices

I have received a copy of Forever Teeth P.L.L.C. Notice of Privacy Practices.

_____

Name

_____

Signature

STAFF WILL COMPLETE THIS SECTION IF NOT OBTAINED

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

☐ Patient refused to sign.

☐ Emergency situation kept us from obtaining the patient's signature.

☐ Language barriers kept us from obtaining the patient's signature.

☐ Other_____

FINANCIAL POLICY

We ask that all patients read and sign this form in addition to completing our Patient Information Forms prior to seeing the dentist. PAYMENT OF SERVICE ARE DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, check, credit cards, and Care Credit. As a courtesy we may accept assignment of insurance benefits; however, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are ***not*** a party to the contract. Our relationship is with you, not the insurance company. We do not get involved in disputes between you and your insurer. Our involvement will be limited to supplying factual information to facilitate claim processing.
2. All charges are your responsibility whether the insurance company pays or does not pay. Your Insurance does not cover all benefits. Some insurance arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-pays are due at the time treatment begins.
3. If your insurance company does not pay in 30 days, it is your responsibility to contact your insurer to expedite payment.
4. If your account incurs an unpaid balance more than 60 days, it *will be subject to a collection agency and will appear on your credit report.*
5. I understand that the staff of Forever Teeth Dentistry P.L.L.C. are not representatives for my insurance company and the estimates I receive from them is not a guarantee of payment from the insurance company.
6. I authorize the office to release any dental information to my insurance carrier and payment from my insurance to be made directly to the dentist.

I understand that I will be charged $35 for any appointment that I miss or fail to call the office and cancel without 24 hour notice.

There is a $35 returned check fee.

Posterior composites (tooth colored fillings) will be discounted according to your insurance plan.

Fixed or removable prosthetics, dentures, or crowns must be seated or finished in a timely manner to insure proper fit. If you fail to have your prosthetic finished within 60 days from the date of the initial impression, a second impression must be made and you will be charged an additional fee. There will be no refund for prosthetics.

Thank you for choosing our office as your dental providers. We appreciate your trust and are glad to have an opportunity to serve you.

Patient, Parent, or Guardian Signature X_____

OFFICE POLICY

The doctors and staff at Forever Teeth Dentistry P.L.L.C. would like to welcome you to our office. In an effort to provide the best of care to all our patients, we ask that you read and understand our policy so that we can better serve you.

1. As a courtesy we attempt to confirm your appointments. Please do not rely on this phone call to keep your appointment. Missed appointments may result in a delay of treatment. We reserve the right to terminate your relationship with us if you have failed three appointments without 24 hour notice.
2. We need to update any changes of insurance, address, or phone numbers. It is your responsibility to make certain that we have your correct phone number so we can notify you in case our doctors have an emergency and need to leave the office. A cellular phone is preferred so that we can contact you immediately.
3. We understand that your time is very important; however, our office is obligated to treat emergency cases that come through unexpectedly. If you have other obligations already scheduled, please inform our staff so that we can reschedule your appointment if the wait is too long for you. We strive very hard to see all of our patients in a timely manner.
4. If you call us and get a busy signal, we are normally busy with other patients, please do not hesitate to leave a detailed message and we will make all efforts to return your call as soon as possible.
5. We ask that you familiarize yourself with our hours of operation. Our office does not take emergency calls or cases beyond normal business hours. In case of an emergency, you need to find another dentist or go to the emergency room and follow up with us during normal bussiness hours.
6. The doctors and assistants would like to mainly focus on the procedure of treatment and will not handle any aspect of the financial responsibility. That duty belongs to our office manager and the front office staff.
7. We seat all patients according to procedure of treatment and not the order that patients sign in.
8. We ask that as a courtesy to our staff and other patients that you turn your cell phone off or to vibrate mode when being called back to the operatory rooms.

The greatest compliment to our office is your referral.

Patient, Parent, or Guardian Signature: X_____

Forever Teeth P.L.L.C. 1305 FM 51, Suite 100 Decatur, TX 76234

(940)626-4441 FAX (940)626-4304

AUTHORIZATION TO RELEASE DENTAL INFORMATION

I hereby authorize Forever Teeth P.L.L.C. to release dental information for:

Patient name: _____

Date of Birth: _____

Please release the following:

☐ X-rays ☐ Treatment record

Other: _____

Purpose of release:

☐ Transfer to another dentist ☐ Attorney/Lawsuit

☐ Insurance purposes Other: _____

X_____

Signature of patient, parent, legal guardian, or authorized representative

_____

Relationship to patient Date

FOR OFFICE USE ONLY

☐ X-RAYS ☐ Treatment records Date released: _____

Staff signature: _____

Forever Teeth P.L.L.C.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize Forever Teeth P.L.L.C. to release information from the dental record of:

Patient Name: _____

Date of Birth: _____

Please release the following:

☐ Entire Record

☐ X-Rays / Imaging

☐ Progress or Treatment Notes

RELEASE INFO TO: _____

RELATIONSHIP TO PATIENT: _____

PURPOSE OF RELEASE: ☐ Transfer to another Dentist

☐ Insurance Purpose ☐ Attorney / Lawsuit Other: _____

I understand that this release can be revoked at any time except to the extent that release made in good faith has already occurred in reliance on the consent. Forever Teeth P.L.L.C., its employees, and staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorize herein.

Signature of patient, parent, legal guardian, or authorized representative:

X _____ Date: _____

Print Name: _____