



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 _____ Burning sensation on tongue Yes No Mouth breathing Yes No

_____ Chew on one side of mouth Yes No Mouth pain, brushing Yes No

Former Dentist _____ Cigarette, pipe, or cigar smoking Yes No Orthodontic treatment Yes No

City/State _____ Clicking or popping jaw Yes No Pain around ear Yes No

Date of last dental visit _____ Dry mouth Yes No Periodontal treatment Yes No

Date of last dental X-rays _____ Fingernail biting Yes No Sensitivity to cold Yes No

Place a mark on "yes" or "no" to indicate if you Food collection between the teeth Yes No Sensitivity to heat Yes No

have had any of the following: Foreign objects Yes No Sensitivity to sweets Yes No

Grinding teeth Yes No Sensitivity when biting Yes No

Bad breath Yes No Gums swollen or tender Yes No Sores or growths in your mouth Yes No

Bleeding gums Yes No Jaw pain or tiredness Yes No How often do you floss? _____

Blisters on lips or mouth Yes No Lip or cheek biting Yes No How often do you brush? _____

Loose teeth or broken fillings Yes No

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

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> 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 _____



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 an effort to obtain an 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.

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

Other _____

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 business 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 take pictures throughout the treatment to help guide us through the process. It is very helpful to discuss cases that are similar and to see before and after photos so that the patients can understand the treatment better.

I, as a patient agree that Forever Teeth may use my photos without my name for any purposes, including teaching, illustration, advertising, and/ or Web or social media.

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**_____

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.

If you finance you treatment plan through a third party, such as Care Credit, it is your responsibility to keep up with payments and interests. We cannot be involved in any disputes that can occur through a third party financing. If you do not finished your treatment plan as agreed at the beginning of treatment, then the interest is your responsibility. Refund through Care Credit will not be giving after 3 days.

If you were giving a discount at the beginning of treatment and did not complete your treatment for any reason, that discount will not apply due to the initial agreement.

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.

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 responsible for additional charges. Removable prosthesis, dentures sometimes do not meet your expectations because everybody anatomy is different and they do not fit and feel like your natural teeth. We suggest adhesives and offer adjustments to help you adapt to your new dentures; however, there will be no refund for fixed and removable prosthetics once they are delivered. Our office and lab will warranty your prosthesis from breakage for 30 days.

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 _____

Forever Teeth P.L.L.C.

1305 FM 51, Suite 100, Decatur, TX 76234

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

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND TREATMENT PLAN

I hereby authorize Forever Teeth P.L.L.C. to release my information to the names provided below through the following forms of communication:

Phone conversation, In person, Text, or Email.

Patient Name: _____

Date of Birth: _____

RELEASE INFO TO: _____

RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____

EMAIL: _____

RELEASE INFO TO: _____

RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____

EMAIL: _____

RELEASE INFO TO: _____

RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____

EMAIL: _____

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: _____