

Welcome to Boerne Family Dentistry

Thank you for taking the time to come see us today. We would like to know you better.

The primary reason for my visit today is to discuss:

In addition to my primary purpose, I would appreciate hearing about these other procedures:

- Teeth whitening and bleaching
- Veneers and cosmetic dental treatments
- Dental Implants
- Snoring Reduction
- Braces
- Replacing silver fillings
- Replace missing teeth

I selected this practice because:

- A personal friend referred me _____
- Convenient location and office hours
- Knowledge that the doctor offers flexible payment terms
- Newspaper or magazine Advertising
- Google
- Yellow page Advertising
- Newsletter
- Postcard
- Other (please explain)

We are pleased to offer our patients an easy monthly payment program. Please indicate which payment options you may be interested in.

- 5% cash discount, for amounts greater than \$300. Full treatment cost must be paid in full with the insurance reimbursing the patient in full. We will provide a claim form for submission. Payment must be cash or check.
- Interest free payment plan offered by one of our financing companies : 6 months or 12 months
- Extended payment plan for 48 months



Adult

Name			
Spouse			
Address			
City	State	Zip	
Home #	Cell or Work #		
Birthday	Social Security #		
Email Address			
Married	Single	Divorced	Widowed

Child

Name		
Address		
City	State	Zip
Home #		
Birthdate	Age	Grade
School		

Emergency Contact

Person to contact
Relationship
Phone #

Dental Insurance

Primary Carrier	
Name of Insured	
Social Security #	Birthday
Employer	
Name of Insurance	
Group #	
Secondary Carrier	
Name of Insured	
Social Security #	Birthday
Employer	
Name of Insurance	
Group #	

Account Information

Person Financially Responsible For Account	
Name	
Relationship to patient	
Employer	
Driver's License #	
Work #	

ASSIGNMENT AND RELEASE

Be advised that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am responsible to pay any deductibles and co pays. I hereby authorize the doctor to release all information necessary to secure payment from carrier. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Dental & Medical History

Name _____

Physician Name _____

Date of Birth _____

Date of last physical _____

Are you under any medical treatment now? If so explain _____ Yes No

Have you had any major operations? If so what? _____ Yes No

Have you ever had a serious accident involving head injury? _____ Yes No

Do you at the present time have any dental complaints? _____

Please check yes or no, if you have or had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS or HIV	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Angina (Chest Pain)	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Type _____			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally (with extractions or surgery)	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Any Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss-unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Cough, Persistent/Bloody	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Xerostomia (Dry Mouth)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapsed	<input type="checkbox"/>	<input type="checkbox"/>	Women:		
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Pace maker	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Nursing	<input type="checkbox"/>	<input type="checkbox"/>
			Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	Taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>

Medications

Please list medications you are currently taking:

Allergies

Please list any drug allergies:

Pharmacy _____

Phone # _____

Have any wounds healed slowly or presented other complications? Yes No

Do you have pain in or near your ear? _____ Yes No

Does any part of your mouth hurt when clenched? _____ Yes No

Have you ever had Novocaine anesthetic? Yes No

Any reactions or allergic symptoms to Novocaine? Yes No

Do your gums bleed? If so, where: _____

Any part of your mouth sore to pressure, cold or sweets? Yes No If so, where _____

Have you used or currently using tobacco products? If so, how many and how often? _____

Do you drink alcohol? Yes No If so, how many and how often? _____ drink(s) per day / week / month

Are you currently on a Corticosteroid treatment? Yes No If so, what for: _____

Signature _____

Date _____

HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice describes how your dental information about you may be used and disclosed and how you can get access to this information.

I hereby authorize Premier Dental Seguin to share:

- Medical health information (health history, medications,allergies, etc.)
- Dental treatment
- Financials regarding dental treatment
- Appointment times,dates and reasons for the visit
- Other _____

with the following people:

_____	_____
Full Name	Relationship
_____	_____
Full Name	Relationship

This authorization does not have an expiration date. But I understand that I may cancel this consent at any time in writing.

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Printed Name of Legal Representative	Relationship