PATIENT INFORMATION CONFIDENTIAL

(PLEASE PRINT)

SS# ____________________

NAME____ BIRTHDATE______________ PHONE#__________________
FIRST MI LAST

ADDRESS____ CITY__________________ STATE________ ZIP __________

NAME OF PERSON RESPONSIBLE/INSURED FOR ACCOUNT______________________ SS#______________ D.O.B.________

PERSON TO CONTACT IN CASE OF AN EMERGENCY________________________________ PHONE#______________

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR NAME______________________ AND RELATIONSHIP TO PATIENT? ____________________

PATIENT MEDICAL HISTORY

PHYSICIAN________________________________ OFFICE PHONE ______________ DATE OF LAST EXAM ______________

	YES	NO
Are you under medical treatment now?	❑	❑
Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years? ____________________	❑	❑
Are you taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking? ____________________		
Has a physician/dentist ever recommended that you take antibiotics prior to dental treatment?	❑	❑

Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
❑	❑	Local Anesthetics (eg. Novocain)	❑	❑	Barbiturates	❑	❑	Aspirin/NSAIDS
❑	❑	Penicillin or other antibiotics	❑	❑	Codeine	❑	❑	Latex
			❑	❑	Sedatives	❑	❑	Other ________
❑	❑	Sulfa drugs	❑	❑	Metal			________
			❑	❑	Iodine			

Do you use tobacco?	❑	❑
Do you use alcohol?	❑	❑
Do you use cocaine or other drugs?	❑	❑

WOMEN ONLY:	YES	NO
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking birth control pills?	❑	❑

Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
❑	❑	Heart Valve Replacement	❑	❑	Thyroid Problem	❑	❑	Stomach Troubles/ ❑ Ulcers ❑ Acid Reflux
❑	❑	High Blood Pressure	❑	❑	Heart Disease	❑	❑	Easily Winded With Exercise
❑	❑	Low Blood Pressure	❑	❑	Hearing Impaired	❑	❑	Hay Fever / Allergies
❑	❑	Heart Attack	❑	❑	Vision Impaired	❑	❑	Tuberculosis
❑	❑	Cardiac Pacemaker	❑	❑	Lupus	❑	❑	Sinus Trouble
❑	❑	Chest Pains/Angina	❑	❑	Heart Murmur	❑	❑	Radiation Therapy
❑	❑	Stroke	❑	❑	Frequently Tired	❑	❑	Glaucoma
❑	❑	Rheumatic Fever/MVP	❑	❑	Anemia	❑	❑	Recent Weight Loss
❑	❑	Swollen Ankles	❑	❑	Emphysema	❑	❑	Liver Disease
❑	❑	Fainting / Seizures	❑	❑	Cancer	❑	❑	Prescription Weight Loss Medication
❑	❑	Asthma	❑	❑	Arthritis	❑	❑	Respiratory Problems
❑	❑	Epilepsy / Convulsions	❑	❑	Joint Replacement or Implant	❑	❑	Osteoporosis
❑	❑	Leukemia	❑	❑	Hepatitis / Jaundice	❑	❑	Other ____________
❑	❑	Diabetes	❑	❑	Sexually Transmitted Disease	❑	❑	Mental Health Disorders
❑	❑	Kidney Diseases	❑	❑	Autoimmune disease			Specify: ____________
❑	❑	AIDS or HIV Infection						

COMMENTS

____

Signature of Dentist Date

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered correctly. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents at time of services.

Signature____ Date_

Boerne Dental Center
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: ____

Address: ___________________________ City: _____________ Zip: ______

Telephone: _______________ Date of Birth: _________________________

Section B: To the Patient- PLEASE READ THE FOLLOWING STATEMENTS

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Laura Hoffman
32350 IH-10 West
Boerne, TX 78006
Phone: (830) 249-2045
Fax: (830)249-6076
E-mail: office@boernedental.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices, I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
Signature: ____________________________________ Date: ___________

If this Consent is signed by personal representative on behalf of the patient, complete the following:

Personal Representative's Name (Please Print) _________________________

Relationship to Patient: ____

You are entitled to a copy of this consent after you sign it.

Dental History Questionnaire

Please complete the following questions to allow us to provide the most appropriate care for your needs.

What is the reason for your visit today? ________________________________

____

How did you hear about us? ______________________________________

Does dental treatment make you nervous or anxious? (Please circle one)

No Slightly Moderately Extremely

When was your last dental visit? ____________________________________

When was your last dental cleaning? __________________________________

Are you satisfied with the appearance of your teeth? (Please circle one) Yes No

What, if anything, would you like to change about your teeth?
____

Do you ever experience any of the following? (Please check all that apply)

___Difficulty opening/ closing jaw
___Clicking or popping of the jaw
___Pain in jaw joint
___Clinching/ grinding
___Unpleasant taste, bad breath
___Bleeding, sore gums
___Frequent blisters, lips/ mouth
___Dry mouth
___Biting cheeks/lips

___Sensitivity to hot
___Sensitivity to cold
___Sensitivity to sweet
___Sensitivity to biting
___Food impaction
___Loose teeth
___Loose dentures
___Uncomfortable Dentures
___Trouble with snoring

Name_____________________ Date__________

Cancellation Policy/No Show Policy & Scheduled Appointments

1. ***Cancellation/No Show Policy for Dentist Appointment***

   Boerne Dental Center understands that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment.

   If an appointment is not cancelled at least 48 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.

2. ***Schedule Appointments***

   Boerne Dental Center understands that delays can happen, however we must try to keep the other patients and doctors on time.

   If a patient is 15 minutes past their schedule appointment time, we will have to reschedule the appointment.

______________________________ ______________

Patient Patient/Guardian Signature Date

Credit Card Information

Credit Card Number ____

Exp Date ________________ CVC ________________

Electronic Communication Agreement

I agree that the Boerne Dental Center may communicate with me electronically at the email address below and text messaging via cell phone.

Cell Phone:_______________________________

Email:____

Patient Name:________________________ Patient Signature:_____________________________

FINANCIAL POLICY

Thank you for choosing the Boerne Dental Center as your Dental healthcare provider. We are committed to providing you and your family with the best available care. In our ongoing process to make sure that all your dental needs are met, our billing department will be available to discuss our fees and this policy with you.

We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the dentist.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit. As a courtesy to you, it is the policy of the Boerne Dental Center to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

(PLEASE INITIAL THE FOLLOWING)

_____1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charges. As your dental provider, we will only supply factual information to facilitate claim processing.

_____2. Fees for services, which include unpaid balances, deductibles, and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement, and collection fees.

_____3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within ninety days, the balance will be due in full from patient. If any payment is made directly to you for services billed by the Boerne Dental Center, you need to recognize and are obligated to promptly remit payment to the Boerne Dental Center.

_____4. You understand and agree that if you fail to make any of the payments for which you are responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by the Boerne Dental Center, you will be responsible for all costs of collecting monies owed, including court costs, collections agency fees, and attorney fees.

_____5. Any non-payment by your insurance after 90 days will become your responsibility. All accounts due past 90 days will be assessed a 2% fee per month based on the account balance.

At the Boerne Dental Center, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call (830) 249-2045.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR MY ACCOUNT.

Printed Name of Patient: ____

______________________________________   ____________________
Signature of Patient or Responsible Party   Date