PATIENT INFORMATION

(PLEASE PRINT)

CONFIDENTIAL

DATE _____

SS# _____

NAME _____ (FIRST / MI / LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS _____ WOULD YOU LIKE NOTICES SENT BY EMAIL? Y N CELL PHONE _____

CHECK APPROPRIATE BOX: ❑ MINOR ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

EMPLOYER _____ WORK PHONE _____

NAME OF PERSON RESPONSIBLE/INSURED FOR ACCOUNT _____ SS# _____ D.O.B. _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

PRIMARY INSURANCE CO. _____ SECONDARY _____

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
If yes, what medication(s) are you taking? _____		
4. Do you use tobacco?	❑	❑
5. Do you use alcohol?	❑	❑
6. Do you use cocaine or other drugs?	❑	❑

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

YES	NO		YES	NO		YES	NO	
❑	❑	Local Anesthetics (eg. novocaine)	❑	❑	Barbiturates	❑	❑	Aspirin
❑	❑	Penicillin or other antibiotics	❑	❑	Sedatives	❑	❑	Other _____
❑	❑	Sulfa drugs	❑	❑	Iodine			

8. 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?	❑	❑

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

YES	NO		YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded
❑	❑	Heart Attack	❑	❑	Heart Murmur	❑	❑	Stroke
❑	❑	Rheumatic Fever/MVP	❑	❑	Frequently Tired	❑	❑	Hay Fever / Allergies
❑	❑	Swollen Ankles	❑	❑	Anemia	❑	❑	Tuberculosis
❑	❑	Fainting / Seizures	❑	❑	Emphysema	❑	❑	Radiation Therapy
❑	❑	Asthma	❑	❑	Cancer	❑	❑	Glaucoma
❑	❑	Low Blood Pressure	❑	❑	Arthritis	❑	❑	Recent Weight Loss
❑	❑	Epilepsy / Convulsions	❑	❑	Joint Replacement or Implant	❑	❑	Liver Disease
❑	❑	Leukemia	❑	❑	Hepatitis / Jaundice	❑	❑	Prescription Weight Loss Medication
❑	❑	Diabetes	❑	❑	Sexually Transmitted Disease	❑	❑	Respiratory Problems
❑	❑	Kidney Diseases	❑	❑	Stomach Troubles/ Ulcers	❑	❑	Osteoporosis
❑	❑	AIDS or HIV Infection	❑	❑	Chest Pains/Angina	❑	❑	Other _____
❑	❑	Thyroid Problem						
❑	❑	Heart Disease						

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
Care☆Compassion☆Comfort
Caring for families in Boerne since 1965

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_____

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 you're 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 you. 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

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.

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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 using the Boerne Dental Center secure email portal.

Email: _____

Patient Name: _____ Patient Signature: _____