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			

	YES	NO
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.

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_____

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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: _____