Patient Information

Date: _____

Patient Name: _____ ☐Male ☐ Female
Last First MI

E-Mail: _____ ☐ Married ☐ Single ☐ Child ☐ Widowed

Birth Date: _____ **Social Security #:** _____ Height:_____ Weight:_____

Phone (Home): _____ (Cell):_____(Work):_____Ext_____

Address: _____
Street Apartment#

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____Reason for this visit: _____
Physician Name: _____Phone #: _____

Have you ever had any of the following? Please check those that apply:

☐AIDS	☐ Diabetes	☐Jaundice	☐Stroke
☐Allergies	☐Dizziness	☐Kidney Disease	☐TMJ (jaw) pain
☐Codeine Allergy	☐Epilepsy	☐Liver Disease	☐ Tuberculosis
☐Penicillin Allergy	☐Excessive Bleeding	☐Mental Disorders	☐ Tumors
☐Other: _____	☐Fainting	☐Mitral Valve Prolapse	☐Ulcers
_____	☐ Glaucoma	☐Nervous Disorders	☐Venereal Disease
_____	☐Growths	☐Pacemaker	☐Other: _____
☐ Anemia	☐Hay Fever	☐Radiation Treatment	
☐Arthritis	☐Head Injuries	☐Respiratory Problems	_____
☐Artificial Joints	☐Heart Disease	☐Rheumatic Fever	
☐Asthma	☐Heart Murmur	☐Rheumatism	_____
☐Blood Disease	☐ Hepatitis	☐Sinus Problems	
☐Cancer	☐High Blood Pressure	☐Stomach Problems	

- Are you pregnant or could possibly be pregnant? ☐Yes ☐ No If yes, due date: _____
- Do you have a history of drug use? ☐Yes ☐ No
  If yes, please explain: _____
- Have you ever had complications following dental treatment? ☐Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐ No
  If yes, please explain: _____
- Are you under the care of a physician? ☐Yes ☐ No
  If yes, please explain: _____
- Treating Physician Name: _____Phone:_____
- Do you have any health problems that need further clarification? ☐Yes ☐ No
  If you yes, please explain: _____

Current Medications and dosages:_____
_____

- Are you currently taking any blood thinners or are you on an Aspirin regiment? ☐Yes ☐ No
- What language is primarily spoken at home? ☐English ☐Spanish ☐Other: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health or medical history, I will inform the staff of East Texas Dental Association without fail.

_____ Date: _____
Signature of patient, parent or legal guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Widowed

Social Security#: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____

Address: _____

Street Apartment#

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code Telephone Number

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient/ friend ☐ Another patient/ family

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ☐ Billboard

Name of person or office referring you to our practice: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and financial responsibility on the part of each patient must be determined prior to treatment.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will assist you with your insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid solely by the insurance company.

A service charge of 11/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months form the date of the patient's examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breech of any time of condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you and/or your assignee, to telephone me at home or at my work to discuss any matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent, or legal guardian

_____ Date: _____ Relationship to Parent: _____

Signature of guarantor of payment/responsible party

East Texas Dental Group
212 Old Grande Blvd, Suite B-224
Tyler, TX 75703
(903)509-0505
(903)509-0506 fax
www.easttxdentalassociates.com

DENTAL INSURANCE

Dental Insurance Policies are contracts between you, the insured, and your insurance company. As a courtesy to you, we will accept payment from your insurance company for the benefits they will provide to lessen your out of pocket expense.

All insurance companies differ with their coverage of the more than 500 universal procedures that are listed under the approved ADA dental codes. Of the over 300 insurance carriers listed within our practice, we cannot guarantee what your insurance will and will not cover. We can estimate your insurance **FOR** you and will do so to the best of our ability, however, it is not always possible to obtain the ALL information necessary to estimate your co-payments EXACTLY.

Your insurance company has specific guidelines of the information they will release to the providers of your dental and medical care. Because of their guidelines, our estimation is indeed just that, **an estimation**. It is not a guarantee of what your insurance will pay, nor of what **YOU'RE** out of pocket expenses will be after the insurance company renders payment. Any unpaid monies are your responsibility for the services we have provided to you.

We appreciate your having picked East Texas Dental Associates to perform your dental care and hope you know we will strive to do all we can to assure your visit with us is as pleasant as possible.

I understand any balance left after insurance payments have been received or in the event of my insurance company's denial of benefits is solely my responsibility. By signing below, I agree I will render payment of any resultant balance once payment has been received from my insurance carrier.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN DATE

_____ _____
PRINTED NAME RELATIONSHIP TO PATIENT

EAST TEXAS DENTAL GROUP
212 Old Grande Blvd, Ste. B-224
Tyler, Texas 75703
903-509-0505

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

East Texas Dental Associates is authorized to disclose information regarding my Personal Health Information with the following:

_____ _____
Name/Relationship Contact number

_____ _____
Name/Relationship Contact number

_____
Patient's Name Parent/Guardian's Name

_____
Signature

_____
Date

You have the right to refuse to sign this document

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):