



How did you hear about our office? _____

Personal Information:

Patient Name _____
Social Security # _____ Birthdate ____ / ____ / ____
Address _____
E-mail _____
Home Phone _____ Mobile _____ Work _____
Employer _____
Occupation _____
Employer Address _____
Spouse/Partner or Guardian's Name _____
Phone _____
In case of emergency, whom should we contact? _____ Phone _____

Responsible Party Information:

Person Responsible for your Account _____
Relationship to Patient _____ Birthday ____ / ____ / ____
Social Security # _____
Primary Dental Insurance Company _____
Group # _____ Subscriber ID # _____
Insured's Employer: _____
Insurance Company Address _____ Phone _____
Do you have dual coverage: YES NO If Yes, Please complete the following:
Secondary Dental Insurance Company _____
Group # _____ Subscriber ID # _____
Insured's Employer: _____
Insurance Company Address _____ Phone _____

Oral Health Information & History:

What brings you into our office today? _____

Are you in pain? Yes No

If yes, how would you describe your current dental problem?

Any sensitivity to heat or cold? Yes No

Pressure? Yes No

Sweets? Yes No

Do your gums bleed when you brush? Yes No

Do you grind your clench your teeth? Yes No

Any pain in your jaw or TMJ issues? Yes No

Do you ever experience dry mouth symptoms? Yes No

Do you or have you ever-used tobacco in any form? Yes No

Have you ever taken medications containing bisphosphonates, like Fosamax, Boniva, or Actonel? Yes No

Date of last dental visit? _____ Former Dentist Name: _____

What was done at the time? _____

Do you have any concerns about having dental treatment?

Have you ever had any serious problems associated with dental treatment? Yes No

If yes, please explain

Do you like the appearance of your teeth? Yes No

If no, please explain _____

Medical Information:

Are you currently under the care of a physician? Yes No

Physician's Name _____ Date of last physical exam _____

Physician's Phone # _____

Please list any medications, blood thinners, vitamins, and/or herbal supplements you are currently taking

Please list any allergies that you have (i.e. medications, latex, metals, local anesthetics, etc.):

PLEASE CIRCLE ANY OF THE FOLLOWING YOU PREVIOUSLY HAD or CURRENTLY HAVE:

- | | | |
|--------------------------|------------------------------------|--------------------------------|
| Heart Failures | Artificial Joints (knee, hip, etc) | Hepatitis |
| Heart Disease or Attack | Kidney Trouble | If yes, which strain, A B or C |
| Angina Pectoris | Ulcers | AIDS |
| Congenital Heart Disease | Diabetes | HIV Positive |
| Heart Murmur | Thyroid Problems | Venereal Disease |
| High Blood Pressure | Glaucoma | Cold Sores/Fever Blisters |
| Arteriosclerosis | Cancer | Blood Transfusion |
| Mitral Valve Prolapse | Emphysema | Hemophilia |
| Artificial Heart Valve | Chronic Cough | Anemia |
| Heart Pacemaker | Tuberculosis | Sickle Cell Disease |
| Heart Surgery | Asthma | Bruise Easily |
| Rheumatic Fever | Hay Fever | Liver Disease |
| Arthritis | Allergies or Hives | Yellow Jaundice |
| Rheumatism | Sinus Trouble | Epilepsy or Seizures |
| Cortisone Medicine | Radiation Therapy | Fainting or Dizzy Spells |
| Drug Addiction | Chemotherapy | Nervousness |
| Stroke | Developmental Disabled | Tumors |
| Allergy to Latex | Allergy to Metal | Osteoporosis |
| High Cholesterol | Allergy to Antibiotics | Allergy to Anesthesia |

Do you have or had any diseases not listed or any conditions we need to know about ?

FOR WOMEN ONLY:

Are you pregnant? Yes No If Yes, What month? _____

Are you nursing? Yes No

Are you taking birth control pills? Yes No

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I also agree to let the doctor know if my health or medications change before my next appointment.

Patient Signature _____ Date _____

(Legal Guardian Signature if Patient is UNDER the 18 YEARS OF AGE)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I have been provided with and understand Cen-Tex Dental's Notice of Privacy Practices. Cen-Tex Dental may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations as described in Cen-Tex Dental's Notice of Privacy Practices.

I give consent to Cen-Tex Dental to call me, leave voicemails, speak directly to family members answering my phone, and send mail and email to the addresses I provided, in reference to any items that assist the practice in carrying out treatment, payment, or operations, such as appointment reminders, billing information, insurance items, and any other information pertaining to my oral health.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Cen-Tex Dental is required to agree to the requested restrictions, if they are reasonable. The restrictions I request are:

I understand that I may revoke this consent in writing, except to the extent that the office has already taken action in reliance thereon.

I have the right to request a copy of Cen-Tex Dental's Notice of Privacy Practices at any time.

By signing below, I hereby certify that I have read and understand the above statements and those statements are true and correct.

PRINTED NAME OF PATIENT

PATIENT SIGNATURE, OR LEGAL GUARDIAN IF UNDER 18

DATE

GENERAL INFORMED CONSENT

I authorize Dr. _____ and/or designated staff to perform such diagnostic aids deemed appropriate to make a proper and thorough diagnosis of my dental needs. Upon such diagnosis I authorize the dentist and/or designated staff to perform all recommended treatments, procedures, and medication administrations as prescribed by the dentist and agreed upon by me, or my legal guardian. I understand that during treatment it may be necessary to change or add procedures to my treatment plan because of conditions found while treating the teeth that were not discovered during examination. I give my permission to the dentist to make all changes and additions to my treatment plan, as necessary.

Medical History: I have disclosed all of my medical history including, but not limited to, any and all drugs and medications that I am currently taking and have taken within the last 72 hours. I have also disclosed all medications, foods, and other substances to which I am allergic.

Radiographs: I understand that the dentist and/or his staff may need to take and evaluate radiographs (x-rays) to aid with proper diagnosis.

Local Anesthesia: I understand that local anesthesia is often used during dental treatment. I further understand that the risks of local anesthesia include, but are not limited to dizziness, nausea, vomiting, increases or decreases in heart rate, allergic reactions that may require medical management or hospitalization, restricted mouth opening, accidental self-injury from biting numb cheeks, lips, or tongue, and/or temporary or permanent numbness, pain, or changed feelings in the teeth, gums, lip, chin and/or tongue (including possible loss of taste).

No Guarantee: I understand that dentistry is not an exact science and that, therefore, dentists cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

Insurance: I assign all dental insurance benefits to which I am entitled to the extent permitted under my insurance policy to Cen-Tex Dental, and authorize Cen-Tex Dental to submit claim forms and receive payments directly with the notation "signature on file". I authorize release of my treatment records, x-rays, and other matters in my file deemed pertinent to my insurance as requested. I agree to be responsible for payment of all services rendered by Cen-Tex Dental on my behalf or to my dependents. I agree that I am responsible for all unpaid claims.

By signing below, I hereby certify that I have read and understand the above statements and those statements are true and correct. My signature below also indicates that I am freely giving my informed consent to authorize Dr. _____ and any authorized staff to perform dental treatment.

PRINTED NAME OF PATIENT

PATIENT SIGNATURE, OR LEGAL GUARDIAN'S SIGNATURE
IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE

FINANCIAL AND APPOINTMENT POLICY

Insurance coverage and participation can not be guaranteed until insurance is verified. We are happy to discuss coverage prior to your visit and check your benefits. All other open plan dental insurances are accepted on an out-of-network basis. If you choose to schedule with an out-of-network provider, you are responsible for all fees not covered by your insurance plan. If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. Your insurance processes the claim and sends you notice of the result (estimation of benefits, or "EOB"). Insurance will typically process claims within 30 days. You will be responsible for any deductibles, co-payments, or balances not covered by insurance.

You are responsible for any balance on your account after 45 days, whether insurance has paid or not. We will be glad to send a refund to you if your insurance pays us. Although rare, some insurance carriers will not reimburse our office directly. In such instances, you will be responsible for the full cost of each visit at the time services are provided, and your insurance company will send you the reimbursement check directly.

Insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Depending on your individual plan, all services may not be covered.

Please understand that we file dental claims as a courtesy to our patients. Claims are filed promptly to expedite communication with your insurance company. It is important for you to keep us informed of any insurance changes such as policy name, group and id number, or a change of employment. We are not, however, responsible for how your insurance company processes the claims or for what benefits are ultimately paid on a claim.

An appointment in our office is reserved specifically for you and the doctor or hygienist.

- If you are unable to make your reserved time, we ask you to call our office during business hours at least 2 business days (48 hours) in advance.
- A "no-show" appointment is simply one where the patient does not call our office or leave a message in accordance with the above guideline.
- On the first no-show appointment, our cancellation fee will be waived.
- On the second no-show appointment, you will be charged a no-show fee of \$75 for every 30 minutes.
- Any further no-shows may result in dismissal from our practice.

We understand life can be busy and unpredictable. If you are running late for an appointment, all we ask is that you call us to keep us informed. This will allow our schedule to flow as smoothly as possible. We will do all we can to adjust our schedule to get you in for your appointment. Our front desk staff will try to accommodate you as best as possible.

By signing below, I hereby certify that I have read and understand the above statements.

PRINTED NAME OF PATIENT

PATIENT SIGNATURE, OR LEGAL GUARDIAN'S IF PATIENT IS UNDER THE AGE OF 18

DATE

Caries Risk Assessment Form (Age >6)

Patient Name:

Birth Date:

Date:

Age:

Initials:

		Low Risk	Moderate Risk	High Risk
Contributing Conditions		Check or Circle the conditions that apply		
I.	Fluoride Exposure (through drinking water, supplements, professional applications, toothpaste)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
II.	Sugary Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes <input type="checkbox"/>		Frequent or prolonged between meal exposures/day <input type="checkbox"/>
III.	Caries Experience of Mother, Caregiver and/or other Siblings (for patients ages 6-14)	No carious lesions in last 24 months <input type="checkbox"/>	Carious lesions in last 7-23 months <input type="checkbox"/>	Carious lesions in last 6 months <input type="checkbox"/>
IV.	Dental Home: established patient of record, receiving regular dental care in a dental office	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
General Health Conditions		Check or Circle the conditions that apply		
I.	Special Health Care Needs (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	<input type="checkbox"/> No	Yes (over age 14) <input type="checkbox"/>	Yes (ages 6-14) <input type="checkbox"/>
II.	Chemo/Radiation Therapy	<input type="checkbox"/> No		<input type="checkbox"/> Yes
III.	Eating Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
IV.	Medications that Reduce Salivary Flow	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
V.	Drug/Alcohol Abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Clinical Conditions		Check or Circle the conditions that apply		
I.	Cavitated or Non-Cavitated (incipient) Carious Lesions or Restorations (visually or radiographically evident)	No new carious lesions or restorations in last 36 months <input type="checkbox"/>	1 or 2 new carious lesions or restorations in last 36 months <input type="checkbox"/>	3 or more carious lesions or restorations in last 36 months <input type="checkbox"/>
II.	Teeth Missing Due to Caries in past 36 months	<input type="checkbox"/> No		<input type="checkbox"/> Yes
III.	Visible Plaque	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
IV.	Unusual Tooth Morphology that compromises oral hygiene	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
V.	Interproximal Restorations - 1 or more	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
VI.	Exposed Root Surfaces Present	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
VII.	Restorations with Overhangs and/or Open Margins; Open Contacts with Food Impaction	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
VIII.	Dental/Orthodontic Appliances (fixed or removable)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
IX.	Severe Dry Mouth (Xerostomia)	<input type="checkbox"/> No		<input type="checkbox"/> Yes

Overall assessment of dental caries risk:

Low

Moderate

High

Patient Instructions: