CEN TEX DENTAL

*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

# First Dental Home
# Visit Documentation

| Patient's Name: | | |
|---|---|---|
| Age (in months): | Date of Visit: | |
| Parent/Guardian at Appointment: | | |
| **Visit Component** | **√** | **Comments/Observations** |
| | | |
| Review of Health History | | |
| Review of Dental History | | |
| Oral Health of Primary Caregiver | | |
| Oral Evaluation | | |
| Caries Risk Assessment | | |
| Toothbrush Prophy or Prophylaxis | | |
| Oral Hygiene Instruction with parent/caregiver | | |
| Anticipatory Guidance | | |
| ❖ Oral Health and Home Care | | |
| ❖ Oral Health of Primary Caregiver/Other Family Members | | |
| ❖ Development of mouth/teeth | | |
| ❖ Oral Habits | | |
| ❖ Diet/Nutrition | | |
| ❖ Fluoride Needs | | |
| ❖ Injury Prevention | | |
| ❖ Medications and Oral Health | | |

**Please note: Abnormal findings should be documented in the patient's record.**

□ Fluoride varnish applied

□ Referral made to: □ Dental Specialist _____
Name of Dental Specialist

Including this visit, how many times has the child had a First Dental Home visit in your office? _____

**PRIVACY NOTIFICATION:** With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See **http://www.dshs.state.tx.us** for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

TEXAS Department of State Health Services
EF08-12881 Rev-0208

# Oral Health Questionnaire

**Child's Name**_____ **Date**_____

**Child's Age** _____ **Child's Date of Birth** _____

| **HEALTH HISTORY** | **Yes** | **No** |
|---|---|---|
| Did the birth mother have any problems during pregnancy? | ☐ | ☐ |
| Was your child premature? | ☐ | ☐ |
| Was your child's birth weight low? | ☐ | ☐ |
| Were there any complications at birth? | ☐ | ☐ |
| Has your child been ill? | ☐ | ☐ |
| Is your child on any medications? | ☐ | ☐ |
| **DIET AND NUTRITION** | | |
| Is/was your child breastfed? | ☐ | ☐ |
| Does your child sleep with a bottle? | ☐ | ☐ |
| Does your child drink from a cup? | ☐ | ☐ |
| Does your child walk around drinking from a bottle or cup? | ☐ | ☐ |
| Is your child on a special diet? | ☐ | ☐ |
| How many times does your child snack each day? _____ | | |
| How many bottles does your child have each day? _____ | | |
| **FLUORIDE ADEQUACY** | | |
| Do you know the fluoride level of your water? | ☐ | ☐ |
| Do you have well water? | ☐ | ☐ |
| Do you use bottled water? | ☐ | ☐ |
| Do you use a water conditioner or filtration system? | ☐ | ☐ |
| If yes, please list _____ | | |
| Do you use fluoride toothpaste for your child? | ☐ | ☐ |
| **ORAL HABITS** | | |
| Does your child use a pacifier? | ☐ | ☐ |
| Does your child suck a thumb or fingers? | ☐ | ☐ |
| Does your child grind his/her teeth day or night? | ☐ | ☐ |
| **INJURY PREVENTION** | | |
| Is your child walking? | ☐ | ☐ |
| Is your home childproofed? | ☐ | ☐ |
| Do you use a car seat for your child? | ☐ | ☐ |
| Has your child had an injury to his/her mouth or face? | ☐ | ☐ |
| **ORAL DEVELOPMENT** | | |
| Does your child have any teeth? | ☐ | ☐ |
| Child's age (in months) when the first tooth came in? _____ | | |
| Has your child had teething problems? | ☐ | ☐ |
| Have you noticed any problems with your child's mouth or teeth? | ☐ | ☐ |
| Does your child complain of mouth pain? | ☐ | ☐ |
| Have any of your children ever had cavities? | ☐ | ☐ |
| Have you or your children ever had a bad dental experience? | ☐ | ☐ |
| **ORAL HYGIENE** | | |
| Do you clean your child's gums/teeth? | ☐ | ☐ |
| Do you use a toothbrush to clean your child's teeth? | ☐ | ☐ |
| Do you use toothpaste to clean your child's teeth? | ☐ | ☐ |

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TEXAS Department of State Health Services
EF08-12878 Rev.02/08

# Dental Risk Assessment Questionnaire

Parents and caregivers – use this form to tell us about the oral health of your child. This will be part of your child's health record.

**Parent/Guardian Name** _____ **Date** _____

**Child's Name** _____ **Child's Age** _____

| | Yes | No |
|---|---|---|
| 1. Does your family drink water with fluoride in it or do your children take fluoride tablets? | ☐ | ☐ |
| 2. Does your child use a toothpaste with fluoride in it? | ☐ | ☐ |
| 3. Do you help your child with toothbrushing? | ☐ | ☐ |
| 4. Have you or your children ever had a bad dental experience? | ☐ | ☐ |
| 5. Have any of your children ever had cavities? | ☐ | ☐ |
| 6. Does your child complain of mouth pain? | ☐ | ☐ |
| 7. Does your child take a bottle to bed? | ☐ | ☐ |
| 8. Does your child walk around drinking from a bottle or cup? | ☐ | ☐ |

9. How many times does your child eat a snack each day? _____

10. How many bottles does your child have each day? _____

11. How is your own dental health? ☐ Good ☐ Fair ☐ Poor

| | Yes | No |
|---|---|---|
| 12. Do you have any cavities? | ☐ | ☐ |
| 13. Do your gums bleed? | ☐ | ☐ |

## Did you know?

**For every 100 school children, more than 5 days of school per year are lost due to dental disease.**

**Good dental health is important!**

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