WELCOME TO KATY DENTAL!

PATIENT INFORMATION

Date_____ Patient's Name_____
Last First Middle

Address_____ City_____ State_____ Zip_____

Home Ph# (___)_____ Work Ph# (___)_____ Cell Ph# (___)_____

Soc. Sec. #_____ Email_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐Single ☐Married ☐ Widowed ☐ Divorced

Patient Employed by_____ Occupation _____

Business Address_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone(___)_____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Middle

Relation to Patient _____ Birthdate _____ Soc. Sec. #_____

Address (If different from patient's)_____ Phone (___)_____

City_____ State_____ Zip_____

Person Responsible Employed By_____ Occupation _____

Business Address _____Business Phone (__)_____

Insurance Company_____ Group #_____

Insurance Co. Address _____ Phone (___)_____

Is patient covered by additional dental insurance? ☐ Yes ☐ No

If yes, please complete the following secondary insurance information.

Insured's Name _____ Relation to Patient _____

Insured's Soc. Sec. # _____ Insured's Birthdate _____

Insurance Company_____ Group #_____

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____ Phone (___)_____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Are you currently under physicians care? ☐ Yes ☐ No If yes, why _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Taking birth control pills/Hormone Therapy ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Emphysema
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS/ARC
- ☐ Jaw Pain TMJ/TMD
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

AUTHORIZATION

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. If there is any change in my medical status, I will inform the dentist. I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read this office's Notice of Privacy Practices. I understand these rules and practices are to guard my personal information and privacy according to HIPAA laws and regulations.

FINANCIAL POLICY

All completed treatment is payable at the time of service IN FULL, unless prior arrangements have been made. We will try our best to estimate your insurance portion, but it is an estimate only. Any balance due will be the responsibility of the patient/guardian.

FOR MINORS - PARENTAL CONSENT

I am the parent/guardian of _____ and I give my consent for all needed treatment to be completed on minor. The work to be performed has been explained to me. I will be notified if any further treatment is indicated, and I agree to be responsible for all charges.

SIGNATURE OF PATIENT: _____ DATE: _____

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DENTAL TREATMENT CONSENT FORM

DRUGS AND MEDICATIONS: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions necessary.

REMOVAL OF TEETH: Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the teeth explained in the treatment plan and all others necessary for reasons in paragraph #2. I understand that removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed; some of which are: pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paraesthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment; the cost of which is my responsibility.

CROWNS, BRIDGES, AND CAPS: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

DENTURES, COMPLETE OR PARTIAL: I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, and color) will be at the "wax try-in" visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

PERIODONTAL LOSS (TISSUE & BONE): I understand that this is a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements, and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

SIGNATURE OF PATIENT: _____ DATE: _____

Payment is due in full at time of treatment unless prior arrangements have been approved.