

# 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 <input type="checkbox"/> M <input type="checkbox"/> F	Age _____	Birthdate _____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>If yes, please complete the following secondary insurance information.</b>			
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:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> 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:

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

### 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: \_\_\_\_\_

# 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.***