Revive
FAMILY DENTISTRY

# Welcome to our office!

**Please take a moment to share your information with us.**

Name: _____ Preferred name:_____

Home address/City/State/Zip Code: _____

_____

Home telephone number: _____ Work phone: _____

Cell Phone: _____ Email address: _____

Date of birth: _____ Social security number: _____

Your occupation: _____ Marital Status: _____

If you are a student, please list the school you are attending: _____

Whom may we thank for referring you to our practice? _____

## *Insurance information…*

Do you have dental insurance? _____ Name of Insured: _____

Insured's employer: _____ Insurance company name: _____

Insurance company phone number: _____ Insurance company group number: _____

Insured's date of birth: _____ Insured's social security number: _____

Please list the member or subscriber ID number if one is provided: _____

Your relationship to the insured: Self Spouse Child Other:_____

## *Emergency contact information…*

Whom may we notify in case of an emergency? _____

Best contact number: _____

Address: _____

**Please answer the following questions so that we may provide optimum care for you…**

Are you currently under the care of a medical doctor? YES NO (*Please Circle)*

If so, please provide the Doctor(s) name and reason for care:_____

Have you been hospitalized or had surgeries within the last year? _____

_____

Are you currently taking any prescription drugs? YES NO (*Please Circle)* If YES, Please list:_____

_____

Are you pregnant or suspect you may be pregnant? YES NO (*Please Circle)*

Do you take birth control? YES NO (*Please Circle)*

Do you have pins, plates, screws, or artificial joints? _____

Have you ever taken Fen-Phen or Redux? YES NO (*Please Circle)*

If YES, did you have a cardio exam? YES NO NA (*Please Circle)*

*PLEASE CIRCLE RESPONSES*

Do you use tobacco? YES NO Do you use alcohol? YES NO Do you use recreational drugs? YES NO

Do you wear contacts? YES NO (*Please Circle)*

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing Bisphosphonates? YES NO

If so, please list medications_____

Are you allergic to any of the following: (*Please Circle*) Aspirin, Penicillin, Codeine, Acrylic, Metal, Latex, Sulfa Drugs

Other allergies:_____

Have you ever bled excessively? YES NO (*Please Circle)*

Have you ever had complications with anesthesia? YES NO (*Please Circle)*

Please answer (*Circle)* all of the following questions about yourself (Current and Past Conditions):

| | | | |
|---|---|---|---|
| **High blood pressure:** | **Rheumatic Fever:** | **Glaucoma:** | **Angina Pectoris:** |
| **Tuberculosis:** | **Chemotherapy:** | **Mitral Valve Prolapse:** | **Liver Disease:** |
| **HIV:** | **AIDS:** | **Hepatitis A, B, or C:** | **Chest pain:** |
| **Yellow Jaundice:** | **Anemia:** | **Blood Transfusion:** | **Hemophilia:** |
| **Sickle Cell Disease:** | **Kidney Trouble:** | **Stroke:** | **Congenital Heart Lesions:** |
| **Scarlet Fever:** | **High Cholesterol:** | **Drug addiction:** | **Hives/Rash:** |
| **Sinus Trouble:** | **Asthma:** | **Emphysema:** | **Arthritis:** |

Please answer (*Circle)* all of the following questions about yourself (Current and Past Conditions):

| | | | |
|---|---|---|---|
| **Rheumatism:** | **Cortisone Meds:** | **Psychiatric Treatment:** | **Shingles:** |
| **Epilepsy:** | **Fainting/Dizziness:** | **Nervousness:** | **Eating Disorder:** |
| **Diabetes:** | **Thyroid Disease:** | **Ulcers:** | **Cold Sores:** |
| **Osteoporosis:** | **Hypoglycemia:** | **Low Blood Pressure:** | **Lung Disease:** |
| **Alzheimer's Disease:** | **Cancer:** | **Excessive Bleeding:** | **Herpes:** |
| **Frequent Cough:** | **Heart Attack/Failure:** | **Stomach Disease:** | **Hemophilia:** |

**Other Conditions: (*Please List)*_____**

***The information I have given today is true and correct to the best of my knowledge. I will inform the doctor/assistant/hygienist if there is any change in my medical or dental status.***

_____

Patient Signature: Date: Doctor's Signature: Date:

# Dental History

**Please answer the following questions so that we may provide optimum care for you.**

Reason for today's visit: _____

How long has it been since you last dental visit? _____ Were dental x-rays taken? _____

Have you ever had an unpleasant experience at a dental office? YES NO

Have you ever had trouble getting numb or a reaction to local anesthetic? YES NO

Are your teeth sensitive to: (*Please Circle)* Heat Cold Biting Pressure Sweets

***(PLEASE CIRCLE RESPONSES BELOW)***

Does your jaw pop or click? YES NO

Do you clench or grind your teeth? YES NO

Are your teeth becoming loose? YES NO

Do you have frequent headaches and sore teeth? YES NO

Do you snore or have you been told that you stop breathing in your sleep? YES NO

Have you ever had braces or other orthodontic treatment? YES NO

Do you feel that your teeth are shifting/moving? YES NO

Do you brush and floss daily? YES NO

Do you have dry mouth? YES NO

Do you gums ever bleed when you brush or floss? YES NO

Is there ever an unpleasant taste or odor in your mouth? YES NO

Do you smoke or use tobacco? YES NO

In general, how do you feel about your overall dental health? _____

Are you dissatisfied with the way your teeth look? If so, please explain (i.e. shape, color, and alignment):

_____

_____

Is there anything that has not been covered on this form that you would like to share with us regarding your overall dental history? _____

***The information I have given today is true and correct to the best of my knowledge. I will inform the doctor/assistant/hygienist if there is any change in my medical or dental status.***

_____

Patient Signature: Date: Doctor's Signature: Date:


OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- For patients with Dental Insurance:
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.
  Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 24-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $80.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $80 cancellation fee will be assessed for the first individual and $50 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**
- Our office will provide confirmation calls. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- Treatment appointments made that **exceed $500.00 will require 10% down** to hold the appointed time.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes Revive Family Dentistry to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Signature_____(Patient, Parent or Guardian)

***This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.***

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 469.340.4002

*Information We Collect About You*

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

*How Your Information Is Used*

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Revive Family Dentistry does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment. *Safeguarding Your*

*Personal and Health Information*

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Revive Family Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Revive Family Dentistry.

*Changes to Our Privacy Policy*

All new patients will review a copy of our privacy policy. Revive Family Dentistry occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

*Your Right to Restrict Use of Information*

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

Signature:_____Date:_____