PATIENT INFORMATION FORM

HARRIS CREEK DENTAL

27487 West Highway 84 ▪ McGregor, TX 76657 ▪ 254-848-9566

Date: _____

Patient Information

□Mr. □Mrs. □Miss □Ms.

LEGAL NAME:

Last:_____

First:_____MI:_____

Preferred Name: _____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____

Mobile Phone:_____

Email:_____

Sex: (Circle) M or F Driver's Lic #:_____

SSN#:_____ DOB:___/____/____

Employer:_____

Employer Phone:_____

Marital Status: (Circle)

Single Married Divorced Separated Widowed

Emergency Contact

Name: _____

Relationship: _____

Phone #: _____

Alternate Phone #: _____

Insurance Information

Primary Ins:_____

Policyholder:_____

ID # or SSN: _____

Group #:_____

Policyholder DOB: _____/_____/_____

Patient's Relationship to Policy Holder: (Circle)

Self Spouse Child Other

Employer: _____

Secondary Ins:_____

Policyholder:_____

Identification # or SSN:_____

Policyholder DOB:_____/_____/_____

Patient's Relationship to policyholder: (Circle)

Self Spouse Child Other

Referral Source

Who may we thank for referring you to our practice? (Circle)

Doctor Family Friend Yellow Pages Flyer

Close to Home/Work Internet Other

Name:_____

The above information is true to the best of my knowledge. I authorize insurance benefits be paid directly to the provider. I understand I am financially responsible for any balance. I authorize Harris Creek Dental or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____

PATIENT HEALTH & DENTAL INFORMATION

MEDICAL HISTORY

Name: _____ Date:_____

Do you have any of the following? (please check)

- _____High blood pressure
- _____Anemia
- _____Arthritis
- _____Artificial Valve
- _____Blood transfusion
- _____Circulatory problems
- _____COPD
- _____Diabetes
- _____Diagnosis of ARC/HIV
- _____Epilepsy
- _____Excessive bleeding
- _____Fainting tendency
- _____Glaucoma
- _____Heart problems (heart murmur, Valve Defect or Replacement)
- _____Hepatitis A (infectious)
- _____Hepatitis B (serum)
- _____Jaundice
- _____Joint Replacement
- _____Malignancies
- _____Nursing mother
- _____Pregnant - Due Date_____
- _____Respiratory problems
- _____Rheumatic fever
- _____Sinus Problems
- _____Stroke
- _____Tested positive for AIDS/HIV
- _____Thyroid disease
- _____Tuberculosis
- _____Unfavorable reaction to dental anesthetic
- _____Venereal disease

Other _____

Do you have a condition that requires antibiotic premedication before dental appointments? Y or N

Do you use any tobacco products? Y or N If YES, what type? _____

Are you allergic to any medications? Y or N If YES, please list. _____

Please list any other allergies. _____

Physician's Name: _____ Phone # :_____

Are you presently under the care of a physician? Y or N If YES, for what? _____ _

Are you currently taking any medications? Y or N If YES, please list. _____

_____

Dental History

Date of your last dental treatment or cleaning: _____

Do you have Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have Bitewing x-rays that are less than 1 year old? _____

Do you have a history of: (please check)

- _____Gum Disease
- _____Abscesses
- _____Sores (ulcers)
- _____Halitosis (bad breath)
- _____Teeth Sensitivities
- _____Cold Sores/Fever Blisters
- _____Grinding Teeth
- _____Clicking or Popping TMJ
- _____Pain in Jaw Joint

Are there any other dental conditions or experiences of which we should be made aware of?

_____

_____

_____

CONSENT FOR SERVICES

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I grant my permission for any and all photographs, intra oral photos, or x-rays to be used for educational purposes as well as my own diagnosis if necessary.

APPOINTMENT POLICY

In this very busy world, we make every effort to schedule your appointment to fit your personal schedule. We do not overbook as do many medical and dental practices. Your appointment is yours exclusively. We ask that you provide us with no less than 48 hours notice should you need to cancel or reschedule an appointment for any reason.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

I, _____, have received a copy of this office's Notice of Privacy Practices.

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the provisions listed below. The following provisions identify our policies governing insurance claims:

• Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our office from your insurance company. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

• We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

• We require you to pay the estimated co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. The co-payment is only an estimate of charges and may be found to be insufficient after review by your insurance company.

• Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

• Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

• Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

• Returned checks are subject to a $25.00 admin fee and all balances older than 60 days will be subject to collection action and fees.

I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

I have read the above conditions of treatment and agree to their content.

Patient/Guardian : _____ Date: _____