Family Dental Corner
9111 FM 723 RD. Ste 400
Richmond ,TX 77406
Tel (832) 980-9111 Fax (832) 944-5311

Welcome! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health

Patient Information

Patient's name _____ **Social Security#:** _____ **Birthdate:** _____
If minor, parents' names _____ **Home phone** _____ **Cell phone** _____
Mailing address _____ **City** _____ **State** _____ **Zip** _____
Employer _____ **Occupation** _____
Spouse's name _____ **Spouse's employer** _____
Whom may we thank for referring you to our office? _____
Email: _____

Medical Health History

Do you have or have you had any of the following?

☐ *yes* ☐ *no* *Cancer or tumor*
☐ *yes* ☐ *no* *Heart Disease*
☐ *yes* ☐ *no* *Heart murmur, mitral valve prolapses, heart defect*
☐ *yes* ☐ *no* *Rheumatic fever or rheumatic heart disease*
☐ *yes* ☐ *no* *Artificial Joint valve*
☐ *yes* ☐ *no* *High or low blood pressure*
☐ *yes* ☐ *no* *Pace maker*
☐ *yes* ☐ *no* *Tuberculosis or other lung problems*
☐ *yes* ☐ *no* *Kidney disease*
☐ *yes* ☐ *no* *Hepatitis or other liver disease*
☐ *yes* ☐ *no* *Alcoholism*
☐ *yes* ☐ *no* *Blood transfusion*
☐ *yes* ☐ *no* *Diabetes*
☐ *yes* ☐ *no* *Neurologic condition*
☐ *yes* ☐ *no* *Epilepsy, seizures, or fainting spells*
☐ *yes* ☐ *no* *Emotional condition*
☐ *yes* ☐ *no* *Arthritis*
☐ *yes* ☐ *no* *Herpes or cold sores*
☐ *yes* ☐ *no* *AIDS or HIV positive*
☐ *yes* ☐ *no* *Migraine headaches or frequent headaches*
☐ *yes* ☐ *no* *Anemia or blood disorders*
☐ *yes* ☐ *no* *Abnormal bleeding after extractions, surgery, or trauma*
☐ *yes* ☐ *no* *Hay fever or sinus trouble*
☐ *yes* ☐ *no* *Allergies or hives*
☐ *yes* ☐ *no* *Asthma*
☐ *yes* ☐ *no* *Osteoporosis*
☐ *yes* ☐ *no* *Do you smoke or use chewing tobacco?*

Are you allergic to, or have you reacted adversely to any of the following?

☐ *yes* ☐ *no* *Latex material*
☐ *yes* ☐ *no* *Penicillin or other antibiotics*
☐ *yes* ☐ *no* *Local Anesthetics ("Novocain")*
☐ *yes* ☐ *no* *Codeine or other narcotics*
☐ *yes* ☐ *no* *Sulfa drugs*
☐ *yes* ☐ *no* *Barbiturates, sedatives, or sleeping pills*
☐ *yes* ☐ *no* *Aspirin*
Other: _____

Are you taking any of the following?

☐ *yes* ☐ *no* *Aspirin*
☐ *yes* ☐ *no* *Anticoagulants (blood thinners)*
☐ *yes* ☐ *no* *Antibiotics or sulfa drugs*
☐ *yes* ☐ *no* *High blood pressure medicine*
☐ *yes* ☐ *no* *Antidepressants or tranquilizers*
☐ *yes* ☐ *no* *Insulin, Orinase, or other diabetes drug*
☐ *yes* ☐ *no* *Nitroglycerin*
☐ *yes* ☐ *no* *Cortisone or other steroids*
☐ *yes* ☐ *no* *Osteoporosis (bone density) medicine*
☐ *yes* ☐ *no* *Bisphosphonates Drugs*
Other: _____

Women:

☐ *May be pregnant*
Expected delivery date: _____
☐ *Taking hormones or contraceptives*

Name of physician: _____

Do you have any disease, condition, or a problem not listed above?

_____

(Please turn over and complete)

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Dental Health History

Patient's name: _____

How often do you brush? _____
How often do you floss? _____
Chief dental complaint _____
Last Dental visit _____

- ☐ *yes* ☐ *no* ***Do you have any jaw symptoms or headaches upon awakening in the morning?***
- ☐ *yes* ☐ *no* ***Do you avoid brushing any part of your mouth because of pain?***
- ☐ *yes* ☐ *no* ***Does your gum bleed easily?***
- ☐ *yes* ☐ *no* ***Does your gum bleed when you floss?***
- ☐ *yes* ☐ *no* ***Does your gum feel swollen or tender?***
- ☐ *yes* ☐ *no* ***Are you apprehensive about dental treatment?***
- ☐ *yes* ☐ *no* ***Have you had problems with previous dental treatment?***
- ☐ *yes* ☐ *no* ***Do you gag easily?***
- ☐ *yes* ☐ *no* ***Does your jaw make noise so that it bothers you or others?***
- ☐ *yes* ☐ *no* ***Do you clench or grind your jaws frequently?***
- ☐ *yes* ☐ *no* ***Do your jaws ever feel tired?***
- ☐ *yes* ☐ *no* ***Does your jaw get stuck so that you can't open freely?***
- ☐ *yes* ☐ *no* ***Does it hurt when you chew or open wide to take a bite?***
- ☐ *yes* ☐ *no* ***Do you have earaches or pain in front of the ears?***
- ☐ *yes* ☐ *no* ***Are you unable to open your mouth as far as you want?***
- ☐ *yes* ☐ *no* ***Do you have a temporomandibular (jaw) disorder (TMD)?***
- ☐ *yes* ☐ *no* ***Have you had a blow to the jaw (trauma)?***
- ☐ *yes* ☐ *no* ***Do you wear dentures?***
- ☐ *yes* ☐ *no* ***Does food catch between your teeth?***
- ☐ *yes* ☐ *no* ***Do you have difficulty in chewing your food?***
- ☐ *yes* ☐ *no* ***Do you chew on only one side of your mouth?***
- ☐ *yes* ☐ *no* ***Have you ever noticed slow-healing sores I or about your mouth?***
- ☐ *yes* ☐ *no* ***Are your teeth sensitive?***
- ☐ *yes* ☐ *no* ***Do you take medications or pills for pain or discomfort? (pain relievers, muscle relaxants, antidepressants)***

Do you feel twinges of pain when your teeth come in contact with:

- ☐ *yes* ☐ *no* ***Hot foods or liquids?***
- ☐ *yes* ☐ *no* ***Cold foods or liquids?***
- ☐ *yes* ☐ *no* ***Sours?***
- ☐ *yes* ☐ *no* ***Sweets?***
- ☐ *yes* ☐ *no* ***Do you have pain in the face, cheeks, jaws, joints, throat, or temples?***
- ☐ *yes* ☐ *no* ***Do you take fluoride supplements?***
- ☐ *yes* ☐ *no* ***Are you dissatisfied with the appearance of your teeth?***
- ☐ *yes* ☐ *no* ***Do you prefer to save your teeth?***
- ☐ *yes* ☐ *no* ***Are you interested in whiter teeth?***
- ☐ *yes* ☐ *no* ***Are you a habitual gum chewer or pipe smoker?***

Signature of patient (or parent): _____ **Date:** _____

Signature of Dentist _____ **Date:** _____

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Patient Consent Form (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I understand that an updated version of Family Dental Corner's Notice of Privacy Practices will be posted on the website and a copy can be provided upon request.

Print Patient Name: _____

Relationship to Patient: _____

Signature of Patient /Legal guardian: _____ Date: _____

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AUTHORIZATION TO RELEASE DENTAL INFORMATION

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

Patient	Patient Last Name	Patient first Name	Date of Birth
Release To:	Name/Organization		Phone
	e-mail		FAX

INFORMATION REQUESTED:

☐ Copy of complete dental chart ☐ Copy of dental x-rays

☐ All treatment rendered

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED:

☐ **Transfer of Records** ☐ **Second Opinion**

☐ **Other, please explain** _____

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it.

_____ _____

Patient Name (Print) Person authorized to sign for patient

_____ _____

Signature Date

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Financial Policy

Welcome to Family Dental Corner!

We are excited to have you as patient and look forward to offering you and your family the finest dental care available.

Before treatment is provided, we will discuss treatment and financial options. This will help you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Payment is due before services are rendered. For your convenience we accept Cash, Visa, Mastercard and Amex.
We also accept “Care Credit” and “Lending Point” which is subject to credit approval. Please ask our friendly staff for more information.

Our fees are based on the quality of materials we use and the time, effort and skills required in performing your needed treatment. We charge what is the usual and customary for our area and will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your benefits. We will be sensitive to your financial circumstances and do everything possible to help you achieve your perfect oral health.
Dental plan benefits are determined by your employer, not your dentist. Your dental policy is a contract between you and your insurance company; therefore, your specific dental plan and payment is your responsibility. Having a dental plan is not a guarantee of payment; and it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you if you present your current dental card and all required information.

Please be aware that by signing this agreement:

- You will be expected to pay for services rendered if this office is unable to verify your dental benefits.
- Any deductible or estimated co-payment amount will be due prior to being taken back for treatment.

If payment for services already rendered has not been paid in full within **45 days**, either by you or your insurance company, the remaining balance for your treatment is considered due and must be collected from you prior to any other treatment being rendered. **Late fee of $50** will be noted on all accounts if the balance is not paid within 90 days of treatment being rendered.

Separated or divorced parents of minors:

The parent that brings the child in to the dental appointment is responsible for paying the co-payment or full fee. If it is necessary, we are happy to hold credit or debit card information on file from the non-custodial parent.
Thank You for your understanding and cooperation.

RESCHEDULING/CANCELLATION POLICY

Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other patients. If you find yourself unable to make your appointment or needing to change your appointment, we do require a minimum of 48 hours' notice so that we may make every effort to accommodate other patients. Appointments cancelled or rescheduled with less than a 48-hour notice or appointments not kept will be subject to a $50.00 fee. _____(**Initial)**

I have read and agree to the Financial Policy and the Rescheduling/Cancellation Policy of Family Dental Corner.

Print Patient Name: _____

Signature of Patient or Responsible Party: _____ Date: _____