2001 Hwy 114, Suite 170 Trophy Club, Texas 76262
Phone: 817.490.9885 or 817.490.5000

Patient Information

Date_____

About You

Name_____
Address_____
City_____State____Zip_____
SSN#_____ **DL#**_____
Home #_____
Work #_____Cell #_____
Birthdate_____ Age_____
Email address _____

About Your Child (if appointment is for your child)

Name_____
Nickname_____
Address_____
City_____State____Zip_____
Home #_____
Work #_____Cell #_____
Birthdate_____Age_____

About Your Dental Insurance

Primary Carrier

Insurance Company_____
Employee_____
Union/Local #_____Emp. Badge #____
Group #_____
Date Employed_____
Employee Soc. Security #_____
Phone # of Insurance Co._____

Secondary Carrier

Insurance Company_____
Employee_____
Union/Local #____Emp. Badge #____
Group #_____
Date Employed_____
Employee Soc. Security #_____
Phone # of Insurance Co._____

About Your Family

Emergency Contact_____
Their Relationship To You_____
Phone Number_____
Address_____
City_____State_____Zip___
Do you have relatives who are patients at our office ?_____ If so who ?_____

About Your Employer

Employer_____
Bus. Address_____City_____
Bus. Phone_____Ext_____
Occupation Of Spouse_____
Employer Of Spouse_____
Bus. Address_____City_____
Bus. Phone_____Ext_____

How did you hear about our office ?_____

Health History Questionnaire

(Medical and Dental Records are Confidential)

Yes **No**

_____ _____1. Have you been treated by a physician in the last two years?
What is the name of your family physician?_____
Address_____Phone #_____

_____ _____2. Have you been hospitalized or treated in an emergency room
Within the past two years? If so, for what condition?
_____

_____ _____3. Are you allergic to any medications? If so please list:
_____

_____ _____4. Are you allergic to latex?

_____ _____5. Are you allergic to any other materials? If yes, please list:
_____

_____ _____6. When you walk up stairs or engage in mild exercise, do you
ever have to stop because of pain in your chest?

_____ _____7. Do you tend to bleed longer than normal from small cuts?

_____ _____8. Have you been diagnosed with mitral valve prolapse or a
pathologic heart murmur due to leaking heart valves?

_____ _____9. Do you use tobacco products? Smoking or chewing?
If yes, please list amount:_____

_____ _____10. Do you drink alcohol? If yes, what amount?
___Light ___Moderate ___Heavy

_____ _____11. Do you have an artificial/prosthetic joint or any kind of shunt
for which your surgeon or physician has specifically asked you
to take antibiotics prior to dental treatment?

Please check any of the following that you have had in the past or presently have:

___Heart disease or attack	___Asthma	___Ulcers
___Angina pectoris	___Bleeding disorder	___Fever blisters
___High blood pressure	___Allergies or hives	___Venereal disease
___Low blood pressure	___Cortisone/Steroids	(syphilis, gonorrhea)
___Congenital heart lesions	___Thyroid disease	___Kidney disease
___Rheumatic/Scarlet fever	___Diabetes	___Kidney dialysis
___Artificial heart valve	___Rheumatism	___Blood transfusion
___Heart pacemaker	___Arthritis	___Hemophilia
___Heart surgery	___Artificial joints	___Sickle cell disease
___Treatment with Phen/Fen	___HIV/AIDS	___Anemia
___Stroke	___Fainting/Dizziness	___Blood thinners
___Emphysema	___Epilepsy/Seizures	___Radiation treatment
___Tuberculosis	___Glaucoma	___Chemotherapy
___Hepatitis	___Drug/Alcohol Dep.	___Cancer or tumor
___Liver disease	___Psychiatric Treat.	___Leukemia

Do you have any other disease, condition or problem not listed?_____If yes, please describe:_____

Please list any medications you are currently taking or have taken within the last six months:_____

Height_____ Weight_____

List the pharmacy you use & location _____ Phone # _____

FOR WOMEN ONLY:

Are you pregnant? Yes _____ No_____ If yes, what month? _____

Are you taking birth control pills? Yes___No___ If yes, what type?_____

_____(To be completed by doctor)_____

Medical Alert

Blood pressure_____

DENTAL HISTORY INFORMATION

Patient Name _____
Wishes to be called _____

Date of last dental visit _____
Date of last cleaning _____
Date of last full set of x-rays _____

1. What concerns have brought you to our office?_____
   _____
2. Tell us about your past dental experiences. Have they been positive or negative?
   _____
3. Is there anything specific about your previous dentist's office that you especially liked? _____ Disliked? _____
4. Is there anything specifically about dentistry that bothers you? _____
5. Is there anything specific that we can do to make your visits more comfortable? _____
   _____
6. Have you ever had any oral surgery or wisdom teeth out?_____
7. Did you wear braces? _____
8. Do you wear a retainer? _____
9. Have you had any treatment on your gums other than routine cleanings? _____
10. Are you aware of any problem areas where food collects between your teeth? _____
11. Do you notice if you grind your teeth while you sleep? Or while awake? _____
12. When you wake up in the morning, do you find that the muscles around your jaw are sore or tired?
    _____
13. Have you ever worn any type of biteguard (also known as night guard or occlusal guard)?
    _____
14. Are any of your teeth sensitive to pressure or chewing?_____
15. Are any of your teeth sensitive to temperature changes? _____
16. Have you had any unusual reactions to dental anesthetics?_____
17. Have you ever been premedicated with antibiotics before a dental appointment?_____
    If so, for what condition?_____
18. Have you ever had an injury to your face or mouth? _____
19. Do you experience dry mouth frequently? _____
20. Do you often have an unpleasant taste in your mouth? _____
21. Do you suffer from bad breath? _____
22. Do you bite your fingernails? _____
23. Circle which type of toothbrush you use: soft bristle medium bristle hard/firm bristle rotary/electric
24. Which best describes your flossing frequency? Every day 3-5 times/week Once/week Once/Month Never

SMILE EVALUATION

1. Are you pleased with the appearance of your teeth when you smile? _____
   If not, what would you change?_____

2. Are there spaces between your teeth that you don't like? _____

3. Are you pleased with the color of your teeth? _____

4. Are you pleased with the shape of your teeth? _____

5. Are your teeth...chipped?_____protruding?_____crowded?_____

6. Do you feel like your teeth are too small or that you show too much gum tissue when you smile? _____

7. Are there old fillings or dental treatment that you aren't happy with?_____
   If yes, please explain_____

8. Is there anything about the shape or alignment of your jaws that you are not happy with?_____

Appointment Policy…

We make every effort to run on time for our patients. As a courtesy to other patients, we ask you to please be on time for your appointments. A delay of even ten minutes can cause us to run late for every patient thereafter. We do not double book appointments. **THE APPOINTMENT TIME YOU HAVE CHOSEN WILL BE RESERVED SPECIFICALLY FOR YOU. PLEASE MAKE YOUR APPOINTMENTS AT A TIME WHEN A SCHEDULE CONFLICT IS LEAST LIKELY TO OCCUR.** A failed appointment inconveniences three people: 1) The patient who missed the appointment whose needed treatment is delayed, 2) the doctor and staff who have spent time setting up and preparing for treatment and 3) a patient in need who could have used that time. **WE RESERVE THE RIGHT TO CHARGE FOR BROKEN APPOINTMENTS OR APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE. THIS FEE MAY BE UP TO $50 PER SCHEDULED HOUR.**

BEST PHONE # TO CALL FOR APPOINTMENT CONFIRMATION _____

Financial Policy…

- Our office requires payment in full at the start of treatment. We accept cash, check, Visa, Mastercard, and American Express
- If approved, you can make monthly payments at no interest for up to 3 months depending upon the amount being financed. This is an excellent option for patients who want to spread out monthly payments over a 3 month period with no interest.

  Our office still collects your portion in full at the start of treatment, but, with this option, you may post-date a check or credit card draft for a portion of this amount to be deposited later. Please feel free to ask for details on this payment method.

Office policy…

Because of safety concerns and infection control precautions, the doctors request that **ONLY THE PERSON RECEIVING TREATMENT BE PERMITTED IN THE TREATMENT AREA. FOR THIS REASON WE DO NOT ALLOW CHILDREN IN THE DENTAL OPERATORIES WHILE THEIR PARENTS ARE UNDERGOING TREATMENT**. Please plan accordingly so that your child has supervision during your appointments. We invite parents into the treatment areas after exams, x-rays and/or procedures are completed on their children to address any questions and discuss your child's dental treatment. We appreciate your understanding on this matter.

I have read and accept the above policies.
Patient signature_____

Information Concerning Your Dental Insurance

Dental insurance is one of the most beneficial and most misunderstood areas in dental treatment today. This explanation will attempt to clear up many common misconceptions about dental insurance.

Dental insurance is a contract between the EMPLOYER and the PATIENT. It has NO CONNECTION at all to the dentist who is providing the dental treatment. The extent of coverage varies greatly from company to company, and sometimes even within a company. It has absolutely NOTHING to do with the level of service provided by the dentist and the fee charged for these services.

An often misunderstood term used by many insurance companies is "UCR" or usual and customary. This "usual and customary" number is the maximum amount that a particular insurance company will pay for a specific procedure. It has nothing to do with the fee charged, but with the level of coverage negotiated by your employer. For this reason, estimates of a patient's portion for any given procedure may not be exact because often there are variations in the amount that the insurance company is willing to pay based on your particular policy.

For example, if a dentist charges $100 for a filling and the coverage is listed at 80%, the patient may assume that their insurance company will pay $80 toward this filling. However, if your policy only ALLOWS $90 for a filling and your policy ALLOWS 80% coverage of this amount, then the insurance company will ACTUALLY pay $72 toward the service, not $80. So instead of the patient paying $20 out of pocket, they will actually be paying $28 (the remainder of the dentist's $100 fee).

This is a common point of confusion because the percentages given by the insurance company are not of the **DENTIST'S FEE** but are percentages of the **ALLOWANCE** of the insurance policy.

Summit Dental Care's policy on dental insurance is as follows: Our office makes every effort possible to assist you with your particular insurance coverage. Although it is not required, we will prepare and submit your insurance forms free of charge as a courtesy. We will also provide an estimate that will show expected insurance reimbursement and patient share for each procedure. Our office can only **ESTIMATE** what the insurance company will cover because most insurance companies will not disclose their exact **ALLOWANCES**. The patient's estimated share will be due at the time of treatment. Should our estimate of the patient's share be too high, a credit will be issued to the account or refunded to the patient if requested. Likewise, if the estimate was low, the remainder of the balance will be due at the time that the insurance payment is received. Should no insurance payment be made within 60 days of a submitted claim, the fee will become the sole responsibility of the patient who may choose to take it up with their insurance company at that time.

By signing below you authorize payment from the insurance company to Summit Dental Care, as well as authorize us to release any information your insurance company may request relating to your dental claims.

Patient Signature _____

Summit Dental Care

Please let us know if you would like a copy of our HIPAA regulations policy.

I have been given the opportunity to review the Notice of Privacy Practices for Summit Dental Care in accordance with HIPPA regulations effective April 14, 2003.

Signed _____
Date:_____