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. Is your child currently under the care of a physician?
If yes, please list reason_____

____ ____ 2. Has your child ever been hospitalized or had surgery?
If yes, please list date & reason_____

____ ____ 3. Is your child taking any medication at present?
If yes, please list_____

____ ____ 4. Has your child had any x-rays taken within the past year?
If yes, please list reason_____

____ ____ 5. Has your child ever had a reaction to any medication?
If yes, please list drug and reaction_____

____ ____ 6. Does your child have an allergy to latex or any materials?
If yes, please list_____

____ ____ 7. Has your child ever had any injury to his/her face, jaws, mouth or teeth? If yes, please explain_____

____ ____ 8. Has your child ever been to the dentist? Date of last visit ____

Please check any of the following medical conditions which your child presently has or has been treated for in the past:

___ Cardiovascular problems
___ Rheumatic fever
___ Scarlet fever
___ Heart murmur (pathologic)
___ Heart surgery
___ Mitral valve prolapse
___ Congenital heart defect
___ Respiratory problems
___ Lung disease
___ Asthma
___ Tuberculosis
___ Endocrine disorders
___ Diabetes
___ Liver disease
___ Hepatitis/Jaundice
___ Genitourinary disorders
___ Kidney disease
___ Bleeding disorders
___ Hemophilia
___ Neurological problems
___ Seizure disorder
___ Cancer
___ Chemotherapy treatment
___ Psychiatric illness
___ Attention deficit disorder
___ Immune system disorders
___ HIV
___ AIDS
___ Gastrointestinal problems
___ Musculoskeletal problems

Does your child have any medical problems not listed above? _____
If yes, please explain_____
Please list the name of your child's physician_____
Address_____ Phone #:_____

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:_____