Texas Wisdom Teeth, PLLC
14856 Preston Rd, Suite 104
Dallas, Texas 75254
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Email: care@texaswisdom.com

PATIENT INFORMATION- Please print

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ Gender: Male or Female DOB: _____ Age: _____

SS#: _____ DL#:_____ E-mail: _____

Address: _____ Apt: _____City: _____ Zip: _____

Best Contact#: _____ Secondary Phone#: _____

Referred By: _____ ***OR*** How did you hear about our office? _____

Who is your: General Dentist? _____ Physician? _____

Pharmacy Name/Address _____ **Phone:** _____

EMERGENCY CONTACT
Name: _____ Phone#: _____

Relationship to Patient: _____

PRIMARY DENTAL INSURANCE
Insurance Company: _____ Insurance Phone #: _____

Policy Holder Name: _____ Relationship to Patient: Self Spouse Parent

Policy Holder DOB: _____SS#:_____ ID#: _____

Policy Holder Employer: _____ Group #: _____

By signing below, I understand that I am financially responsible for all charges. I also understand that in the event of appointment alterations without adequate advance notice of at least 48 hours, additional charges may apply.
I hereby authorize direct payment of my insurance benefits to Texas Wisdom Teeth, PLLC for services rendered to my dependents or me by Texas Wisdom Teeth, PLLC. I understand that it is my responsibility to know my insurance benefits, and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Texas Wisdom Teeth, PLLC is unable to collect from my insurance carrier for whatever reason.

Signature of Patient/Patient's Guardian: _____ Date:_____

Patient Name:_____ Date: _____

HEALTH HISTORY

To our patients: As your oral surgery practice, our primary concern is your overall health. Health problems you may have or medications you are taking can play an important role in the care you will be receiving.

Overall health: □ **Good** □ **Fair** □ **Poor** **Height:** _____ **Weight:**_____

Medical History: Please check any of the following conditions which YOU have had or presently have:

□ AIDS/HIV/Hep C	□ Eye disease/Glaucoma	□ Malignant hyperthermia
□ Arthritis or joint disease	□ Fainting spells	_____ muscle/neuromuscular
□ Artificial joints	□ Gall Bladder trouble	disorder
□ Asthma	□ Hay fever/sinus problems	_____ muscle spasms
□ Blood disorder	□ Heart Attack	_____ dark or chocolate urine
□ Blood transfusion	□ Heart Murmur	_____ unanticipated fever
□ Bronchitis	□ Heart surgery	following anesthesia or exercise
□ Bruise easily	□ Hemophilia	□ Muscular dystrophy/disorders
□ Cancer, tumor or growth	□ Hepatitis/Liver Disease/Jaundice	□ Pain & clicking of jaw
□ Cardiac pacemaker	□ High Blood Pressure	□ Sexually transmitted disease
□ Chemotherapy/Radiation	□ Illicit Drug Use	□ Sleep Apnea
□ Chest pain	□ Immunological disorder	□ Special Needs (ADD/ADHD/MR/
□ Convulsions, Epilepsy	□ Irregular heartbeat	Down Syndrome/Autism)
□ Damaged heart valves/MVP	□ Kidney Trouble/Dialysis	□ Stomach Ulcers
□ Diabetes	□ Low blood sugar	□ Stroke
□ Difficulty breathing	□ Low blood pressure	□ Thyroid trouble
□ Emphysema	□ Mental health problems	□ Tuberculosis

□ **Other:** _____

I have read all the above conditions and unless otherwise marked, I am stating I do not have, nor have ever had any of these conditions. Signature of Patient/Patient's Guardian: _____

Have you ever been told you are at risk for malignant hyperthermia?	**YES**	**NO**
Has a family member ever been told they are at risk for malignant hyperthermia?.....	**YES**	**NO**
Do you have a family history of unexpected death(s) following general anesthesia?	**YES**	**NO**
Have you undergone General Anesthesia before?	**YES**	**NO**
Have there been any changes to your general health in the past year?	**YES**	**NO**
Are you under the care of a physician? Date of last visit: _____	**YES**	**NO**
If so, what are you being treated for? _____		
Have you had any illness, operation or been hospitalized in the past?	**YES**	**NO**
If so, describe. _____		
Do you have unhealed injuries, growths, sore spots or inflamed areas in or around your mouth? If so, where? _____	**YES**	**NO**
Is the condition we are seeing you for today due to an accident?	**YES**	**NO**

Surgical History:

□ Appendectomy	□ Facial/cosmetic	□ Pacemaker	□ CABG
□ Gall Bladder	□ Tonsillectomy	□ Coronary Stent	□ Neck/Back

□ Other: _____

I have read all the above surgeries and unless otherwise marked, I am stating I have never undergone any surgeries. Signature of Patient/Patient's Guardian: _____

Have you ever had any serious illness not listed? (Please describe) _____

_____

Patient Name:_____ **Date:** _____

ALLERGIES

Are you allergic to **Penicillin**? **YES NO** What is the reaction?_____

Any other allergies?	What is the reaction?

LIFESTYLE

Occupation: _____

Exercise? **YES NO** If yes, Type: _____ Frequency: _____ Hours per week: _____

Tobacco Use? ☐Never ☐Current ☐Former, Year quit?_____

Tobacco type: _____ How many per day?: _____ Years used: _____

Caffeine: **YES NO** Type: Coffee Tea Soda Amount: _____

Alcohol: **YES NO** Amoun

Illicit Drug use: **YES NO** If yes, previous history of drug abuse? _____

_____

For Females Only:

When was your last menstrual period? _____

Is there a possibility that you may be pregnant?..... **YES NO**

If yes, estimated delivery date:_____

Are you nursing? ..... **YES NO**

Are you taking birth control pills? ..... **YES NO

** ***PRECAUTION:*** *If an antibiotic is prescribed for you, and you are currently taking birth control pills, please be aware that the drug prescribed may interfere with the effectiveness of your birth control. The result could be an unplanned or unexpected pregnancy.* ***Discuss using other methods of birth control with your prescribing doctor.***

****

I certify that I have read and **understand** the above medical information I have provided. I acknowledge that my questions, if any, about the inquiries set forth above are answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions I have made in the completion of this form.

Signature of Patient/Patient's Guardian: _____ **Date:**_____

Patient Name:_____ **Date:** _____

MEDICATIONS

Are you taking or have you ever taken any of the following:

Bisphosphonates? **(used to treat osteoporosis or breast cancer)**
For example: Boniva, Fosamax, Actonel, Zometa, Xgeva ..... **YES** **NO**

Anticoagulants? For example: Coumadin, Warfarin, Aspirin, Plavix?..... **YES** **NO**

Medications: Please list any medications you are currently taking below:

Name of Drug:	Strength:	Times per day:

Patient Name:_____ **Date:** _____

INSURANCE

In today's world of insurance, understanding each policy can be challenging for the patient as well as your dental team. Every employer along with the insurance company negotiates the benefits and exclusions of the policy to come up with the best premiums for the employer and employee. Sometimes, in order for premiums to be affordable, the benefits offered might not include everything that is needed to care for the patient.

We verify your insurance and get a general benefit summary **as a courtesy** for our patient. At that time, we are informed from the insurance company that the information **is not a guarantee of payment**, therefore; we are unable to guarantee any portions paid by the insurance company. ***Insurance is ultimately a contract between the policyholder and the insurance.***

At the initial exam, you will be provided with a detailed treatment plan, which will give you an **estimate** of your portion ***due at time of service***. This will also provide you with the necessary codes in the event you have questions for your insurance company pertaining to coverage.

PAYMENT POLICY

Payment for today's visit and future visits are due at the time of service, prior to being seated for surgery.

Payment Options:

- Cash/Cashier's Checks ***NO PERSONAL CHECKS***
- Credit/Debit Cards – containing Visa, Master Card, AMEX and Discover logos
- Care Credit – a separate line of credit, see specifics below
    - Application and approval process takes less than 10 minutes
    - Can be used for entire family
    - Accepted by other professionals
- FSA/HSA Cards with the Visa or MasterCard logos

If applicable, as a courtesy, insurance claims will be filed by Texas Wisdom Teeth, PLLC and I am responsible for paying my estimated portion **at the time of service**. I understand that if for any reason the account balance is not paid in full within sixty days of the initial visit, it becomes my responsibility without exception. In the event the account should have a balance ninety days from the initial date of service, and the account is turned over to a collection agency, I will be responsible for any collection/legal fees associated with the collection of the balance.

Additional payment policies:

- Responsibilities for payments who are minor children, whose parents are divorced, rest with the parent who seeks the treatment (This parent is the guarantor). Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Texas Wisdom Teeth, PLLC.
- Self-pay patients: Payment is due at the time service is rendered unless other arrangements have been made in advance. For your convenience, we accept cash, cashier's check, Care Credit, VISA, Master Card, Discover and American Express.

- You must provide your most current billing address, all available telephone numbers and any important contact information. If this information changes it is your responsibility to contact us with your updated information.
- If your insurance company requires your social security number to file a claim, you will be required to provide it or pay for services received at time of service. We require that payment of deductible, co-pays and coinsurance be paid at the time of service. You are financially responsible for services not covered by your insurance company.
- Texas Wisdom Teeth, PLLC Billing Coordinators are available to help you with your billing questions Monday-Thursday between 8:00am and 4:00pm by calling (972) 960-1111.

By signing below, I understand that I am financially responsible for all charges. I also understand that in the event of appointment alterations without adequate advance notice of at least 48 hours, additional charges may apply.
I hereby authorize direct payment of my insurance benefits to Texas Wisdom Teeth, PLLC for services rendered to my dependents or me by Texas Wisdom Teeth, PLLC. I understand that it is my responsibility to know my insurance benefits, and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Texas Wisdom Teeth, PLLC is unable to collect from my insurance carrier for whatever reason.

RESPONSIBLE PARTY **{Must be present to fill out and sign.}**

First Name: _____MI: _____ Last Name: _____ DOB: _____

Relation to patient: _____ SS#: _____ DL#:_____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell Phone#: _____ Work Phone#: _____

Print Patient's Name: _____ Patient's DOB: _____

Signature of Patient/Patient's Guardian: _____ Date:_____

Patient Name:_____ Date: _____

HIPAA Privacy Policy

In General, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner **(*check all that apply*):**

- □ Cell Phone_____
  _____ OK to leave a message with detailed information
  or
  _____ Leave a message with callback number only

- □ Work Telephone_____
  _____ OK to leave a message with detailed information
  or
  _____ Leave a message with callback number only

- □ Written Communication
  _____ OK to mail to my home address: _____

  _____ OK to mail to my work/office address: _____

  _____ OK to fax to the following number: _____

  _____ OK to email to: _____

I allow you to give my clinical information to or answer questions from the following person(s), Please give full name of each:

Spouse_____ Parent_____ Child_____

Escort _____ Other_____

If None, please initial: _____

HIPAA Acknowledgement

By signing below, I acknowledge that a copy of this practice's **Notice of Privacy Practices (HIPAA)** is available to me at my request, and I have been given the opportunity to ask any questions I may have regarding this notice.

Signature of Patient/Patient's Guardian: _____ Date: _____