Texas Wisdom Teeth, PLLC
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PATIENT INFORMATION - Please print

First Name: _____ MI: _____ Last Name: _____

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

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

Street Address: _____City: _____ Zip: _____

Contact#: _____ Work Phone#: _____

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

Who is your: General Dentist? _____ Physician? _____

IN CASE OF EMERGENCY

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 #: _____

I hereby authorize the payment of dental and/or medical benefits to the rendering provider for Services provided.

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

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: _____

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 or HIV
□ Arthritis or joint disease
□ Artificial joints
□ Asthma
□ Blood disorder
□ Blood transfusion
□ Bronchitis
□ Bruise easily
□ Cancer, tumor or growth
□ Cardiac pacemaker
□ Chemotherapy
□ Chest pain
□ Contact lenses
□ Convulsions, epilepsy
□ Damaged heart valves/MVP
□ Diabetes
□ Difficulty breathing
□ Emphysema
□ Eye disease/glaucoma
□ Fainting spells
□ Gallbladder trouble
□ Habit forming/illegal drugs
□ Hayfever/sinus problems
□ Heart attack
□ Heart murmur
□ Heart surgery
□ Hemophilia
□ High blood pressure
□ Immunological disorder
□ Irregular heart beat
□ Jaundice, hepatitis or liver disease
□ Kidney trouble; dialysis
□ Low blood sugar
□ Low blood pressure
□ Mental health problem
□ Malignant hyperthermia
__ dark or chocolate urine
__ muscle/neuromuscular disorder
__ muscle spasms
__ unanticipated fever following anesthesia or exercise
□ Muscular dystrophy/disorders
□ Pain & clicking of jaw
□ Radiation therapy
□ Sexually transmitted disease
□ Stomach ulcers
□ Stroke
□ Thyroid trouble
□ Tuberculosis

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

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

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**?_____What is the reaction?_____

Any other allergies?	What is the reaction?

MEDICATIONS

Are you taking or have you ever taken any of the following:	YES	NO
Bisphosphonates? (used to treat osteoporosis or breast cancer) For example:		
Boniva, Fosamax, Actonel, Zometa, Xgeva	☐	☐
Anticoagulants? Coumadin, Warfarin, Aspirin, Plavix?.....	☐	☐

Medications: Please list any medications you are currently taking

Name of Drug:	Strength:	Times per day:

***Please use attached blank form if additional space is needed.**

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:_____ Amount: _____

Alcohol: ☐YES ☐NO Amount: _____

WOMEN

	YES	NO
When was your last menstrual period? _____		
Is there a possibility that you may be pregnant?.....	☐	☐
If yes, estimated delivery date:_____		
Are you nursing?	☐	☐
*Are you taking birth control pills?	☐	☐

**** 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**. 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

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 do verify your insurance and get a general benefit summary as a courtesy for our patient. At this 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.

Payment Options:

- Cash – includes money orders
- Personal Check – no temporary 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.

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 (24 hour) notice, additional charges may apply.

RESPONSIBLE PARTY MUST BE PRESENT TO SIGN BELOW

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

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

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

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

Print Patient's Name: _____ Date:_____

Signature of Financially Responsible Party listed above: _____

Patient Name_____ **Date** _____

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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*)**:

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

□ 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_____

Other_____ Escort_____ None_____

_____ _____
Patient Signature (If patient is unable to sign, please indicate relationship) Date

_____ _____
Witness Signature Date