

7825 Hwy 6 N Ste 109
Houston, TX 77095
281-463-3538 phone
281-463-3730 fax



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name:
Last First MI Preferred Name

Title: Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: Email Address:

Phone:
Home Work Ext Mobile

Address:
Street Address

City State Zip Code

Whom may we thank for referring you to our practice?

- | | | |
|--|---|---|
| <input type="checkbox"/> Website | <input type="checkbox"/> Internet | <input type="checkbox"/> Direct Mail |
| <input type="checkbox"/> Newsletter | <input type="checkbox"/> Angies list | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Sign/Location | <input type="checkbox"/> Patient (name below) | <input type="checkbox"/> Other (name below) |

Name of person, office or other source referring you to our practice:

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Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment neither-not applicable

Name:
Last First MI Preferred Name

Title: Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: Social Security #:

Phone:
Home Work Ext Mobile

Address if different
Street Address

City State Zip Code

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Dental Insurance Information

Primary Dental Insurance:

Name of Insured:
Last First MI

Insured Birth Date: ID/SS # Group #

Insured Address if different
Street Address

City State Zip Code

Insured's Employer Name:

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Plan Phone:

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:		YES	NO		YES	NO	
1.	hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2.	an allergic reaction to			27.	arthritis, rheumatoid arthritis, lupus _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28.	glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> penicillin			29.	contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> erythromycin			30.	head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> tetracycline			31.	epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> sulfa			32.	neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> local anesthetic			33.	viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> fluoride			34.	any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> metals (nickel, gold, silver, _____)			35.	hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> latex			36.	STI / STD _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> other _____			37.	hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3.	heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	38.	HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4.	history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39.	tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5.	artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40.	radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6.	pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41.	chemotherapy, immunosuppressive _____	<input type="checkbox"/>	<input type="checkbox"/>
7.	artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	42.	emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8.	rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43.	psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9.	high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44.	antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10.	a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45.	alcohol / street drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
11.	anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:			
12.	prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	46.	presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
13.	emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47.	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
14.	tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	48.	taking medication for weight management (i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
15.	asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	49.	taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
16.	breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	50.	often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
17.	kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51.	experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
18.	liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	52.	a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
19.	jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	53.	considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
20.	thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54.	often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21.	hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	55.	FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22.	high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	56.	FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23.	diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>	57.	MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24.	stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>				
25.	digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>				

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Name _____ Nickname _____ Age _____
 Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY 

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [] _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed? _____ YES NO

GUM AND BONE 

7. Do your gums bleed or are they painful when brushing or flossing? _____ YES NO
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ YES NO
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
10. Is there anyone with a history of periodontal disease in your family? _____ YES NO
11. Have you ever experienced gum recession? _____ YES NO
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ YES NO
13. Have you experienced a burning sensation in your mouth? _____ YES NO

TOOTH STRUCTURE 

14. Have you had any cavities within the past 3 years? _____ YES NO
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ YES NO
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ YES NO
18. Do you have grooves or notches on your teeth near the gum line? _____ YES NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES NO
20. Do you frequently get food caught between any teeth? _____ YES NO

BITE AND JAW JOINT 

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ YES NO
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ YES NO
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ YES NO
25. Are your teeth crowding or developing spaces? _____ YES NO
26. Do you have more than one bite and squeeze to make your teeth fit together? _____ YES NO
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES NO
28. Do you clench your teeth in the daytime or make them sore? _____ YES NO
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ YES NO
30. Do you wear or have you ever worn a bite appliance? _____ YES NO

SMILE CHARACTERISTICS 

31. Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
32. Have you ever whitened (bleached) your teeth? _____ YES NO
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ YES NO
34. Have you been disappointed with the appearance of previous dental work? _____ YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I have read and understand the HIPAA policy.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____

Date: _____

Relationship to Patient:



OFFICE POLICIES

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our OFFICE POLICIES. If you have any questions, please ask the front desk.

1. **VERIFYING INSURANCE:** As a courtesy to you, we will verify your insurance for eligibility benefits prior to your new patient appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. **You are ultimately responsible** for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, are your financial responsibility.
2. **PAYMENT:** Payment is due at the time of service. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.
3. **INSURANCE INFORMATION:** New Insurance as well as changes in INSURANCE must be provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being your responsibility.
4. **CHANGES IN PERSONAL INFORMATION:** Changes in your address or telephone numbers should be kept current with our office.
5. **REQUESTS FOR ADDITIONAL INFORMATION:** These must be responded to immediately. Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being your responsibility.
6. **PAYMENT PLANS:** Our office offers Third Party Financing if needed to assist you in paying for any necessary treatment.
7. **BALANCES:** If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collections agency. If this happens, a collection fee (currently 39% of the balance) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus.
8. **RETURNED CHECKS:** There will be a \$30 fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. Once a check has been returned, this office will no longer accept personal checks for payment.
9. **CANCELLATIONS / FAILED APPOINTMENTS:** We request 24-hours notice if you are cancelling an appointment. There will be a \$50 fee for cancellations made without 24 hours notice and for failed appointments ("no shows"). The \$50 will be posted to your account, and you will not be allowed to make any other appointments for yourself or your family members until it is paid in full.

*** Thank you for reading this information in full. Please sign below to acknowledge your understanding of the OFFICE POLICIES ***

Patient or Guardian Signature _____ Date _____

Patient Name (Please Print) _____