

# **PERSONAL HISTORY**

		Date:
Patient Name: _		
Address:		
City/State:		Zip Code:
Sex:	Marital Status ( <i>circle</i>	eone): S M D W Sep
	Spouse's Name:	
Date of Birth:	//	Home Phone:
Social Security N	Number:	_ Cellular Phone:
Employer:		Work Phone:
Occupation:		
Employer Addre	:SS:	
City/State:		Zip Code:
Driver's License	State/Number:	
Email address: _		
Would you like t reminders, etc v	o receive notifications f ia EMAIL? Circle One	from our office regarding appointments, treatment Yes/No via TEXT? Circle One Yes/No
Referred By:		
REASON FOR TO	DDAY'S VISIT:	

### **FINANCIALLY RESPONSIBLE PERSON**

(if other than patient)

Responsible Person:		
Address:		
City/State:	Zip Code:	
Sex:	Marital Status (circle one): S M D W Sep	
	Spouse's Name:	
Date of Birth://	Home Phone:	
Social Security Number:	Cellular Phone:	-
Employer:	Work Phone:	
Occupation:		
Employer Address:		
City/State:	Zip Code:	
Driver's License State/Number:		
Email address:		
	<b>cations from our office regarding appointmer</b> /No <b>via TEXT? Circle One</b> Yes/No	ıts, treatment reminders,
DENTA	L INSURANCE INFORMATION	
Insured Name:	Social Security #:	
Employer Name:	ID#: Group #:	
Insurance Co Name:	Insurance Co Phone:	
Insurance Company Address: _		
City:	State: Zip Code:	
Insured Signature		
Patient/Responsible Party Signa	ature Date:	

#### Patient Medical History

Austin General Dentistry, PLLC

Date:\_\_\_\_\_

Although dental personal primarily treat the area in and around your mouth, your oral cavity is an important part of your entire body. Health issues that
you may have or medications that you may be taking could have an important interrelationship with your oral cavity and thus with the dental treatment you
may receive. Thank you for answering the following questions in detail to the very best of your knowledge.

may receive. Indilk yo	a ioi answeillig	g the following question		very best of your know	ieuge.		
Are you under a physicia	an's care now?	Yes O No O		If yes please explain:			-
a major operation?		Yes O No O		If yes please explain:			-
Have you ever had a ser neck injury?	ious head or	Yes O No O		If yes please explain:			_
Are you taking any med				If you plages avalais			
or drugs, including over medication/vitamins?	the counter	Yes O No O		ii yes piease explain:			_
Do you take/have you ta	aken, Phen-	Yes O No O		If ves please explain.			
Fen/Redux? Do you, or have you eve	or takon			in yes piedse explaini			-
medications containing bisphosphonates? (Fosa Actonel)		Yes O No O		If yes please explain:			-
Do you use controlled su	ubstances?	Yes O No O		If yes please explain:			_
Do you use tobacco?		Yes O No O		If yes please explain:			_
Women Patients: Are yo	ou:						
O Pregnant/Trying to ge		O Nursin	g?	O Taking oral contrace	otives?		
Are you allergic to any c	of the following?			0		0	
O Aspirin		O Penicillin		O Codine		O Acrylic	
O Metal/Nickel		O Latex		O Sulfa Drugs		O Local Anesthetics	
Other? O		lease explain:					
Do you have, or have yo		e following:		1			
AIDS/HIV Positive	Yes O No O	Cortisone Meds	Yes O No O	Hepatitis B or C	Yes O No O	Renal Dialysis	Yes O No O
Alzheimer's Disease	$_{Yes} \ O \ _{No} \ O$	Diabetes	Yes $O$ No $O$	Herpes	Yes $O$ No $O$	Rheumatic Fever	Yes $O$ No $O$
Anaphylaxis	$_{Yes} \ O \ _{No} \ O$	Drug Addiction	$_{Yes} \ O \ _{No} \ O$	High Blood Pressure	$_{Yes} \ O \ _{No} \ O$	Rheumatism	Yes $O$ No $O$
Anemia	$_{Yes} \ O \ _{No} \ O$	Easily Winded	$_{Yes} \ O \ _{No} \ O$	High Cholesterol	$_{Yes} \ O \ _{No} \ O$	Scarlet Fever	$_{Yes} \ O \ _{No} \ O$
Angina	Yes $O$ No $O$	Emphysema	Yes $O$ No $O$	Hives or Rash	Yes O No O	Shingles	Yes O No O
Arthritis/Gout	Yes O No O	Epilepsy/Seizures	Yes O No O	Hypoglycemia	Yes O No O	Shunt	Yes O No O
Artificial Heart Valve	Yes O No O	Excessive Bleeding	Yes O No O	Irregular Heartbeat	Yes O No O	Sickle Cell Disease	Yes O No O
Artificial Joint	Yes O No O	Excessive Thirst	Yes O No O	Kidney Problems	Yes O No O	Sinus Trouble	Yes O No O
Asthma	Yes O No O	Fainting/Dizziness	Yes O No O	Leukemia	Yes O No O	Spina Bifida	Yes O No O
Blood Disease	Yes O No O	Frequent Cough	Yes O No O	Liver Disease	Yes O No O	Stent	Yes O No O
Blood Transfusion	Yes O No O	Frequent Diarrhea	Yes O No O	Low Blood Pressure	Yes O No O	Stomach/Intestinal	Yes O No O
Breathing Problems	Yes O No O	Frequent Headaches	Yes O No O	Lung Disease	Yes O No O	Stroke	Yes O No O
Bruise Easily	Yes O No O	Glaucoma	Yes O No O	Mitral Valve Prolapse	Yes O No O	Swelling of Limbs	Yes O No O
Cancer	Yes O No O	Hay Fever	Yes O No O	Osteopenia	Yes O No O	Thyroid Disease	Yes O No O
		,				,	
Chemotherapy	Yes O No O	Heart Attack/Failure	Yes O No O	Osteoporosis	Yes O No O	Tonsillitis	Yes O No O
Chest Pains	Yes O No O	Heart Murmur	Yes O No O	Pain in Jaw Joints	Yes O No O	Tuberculosis	Yes O No O
Cold Sores/Fever Blisters	s Yes O No O	Heart Pacemaker	Yes O No O	Parathyroid Disease	Yes O No O	Tumors and Growths	Yes O No O
Conginital Heart Disorde	Yes O No O	Heart Trouble/Disease	$_{Yes} \ O \ _{No} \ O$	Psychiatric Care	$_{Yes} \ O \ _{No} \ O$	Ulcers	$_{Yes} \ O \ _{No} \ O$
						1	
Convulsions	Yes O No O	Hemopilia	Yes O No O	Radiation Treatments	Yes O No O	Yellow Jaundice	Yes O No O

Have you ever had any serious illness not listed?

Yes O No O If yes please explain:

Comments:

Patient Name:\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect informationcan be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

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Signature of Patient, Parent or Guardian

Date:\_

# RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Austin General Dentistry, PLLC 7800 North Mopac Expressway, Suite 330 Austin, Texas 78759

#### \*\*\*\*\*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT\*\*\*\*\*\*

I,	, have been provided with a copy of Austin General Dentistry's
Notice of Privacy Practices.	

Patient/Responsible Party Name:		 
Relationship to Patient:		
Signature:	Date:	

A copy of these Notices is always available at the front office for viewing, and a hard copy can be provided to you at any time free of charge.

	<b>OFFICE USE ONLY:</b>
I attempted to obtain a signature unable to do so as documented b	e in acknowledgement of this Notice of Privacy Practice's Acknowledgement, but was velow:
Date:	Reason:
Employee Initials:	

# **CANCELLATION POLICY**

If you are unable to keep an appointment, we kindly ask that you give our office at least 48 hours' notice of this cancellation to avoid a *failed appointment charge* of \$50. We understand that issues may arise unexpectedly, and we will make every attempt to contact you via phone or email to confirm your appointment. It is your responsibility to inform our office of any changes in your contact information so that we will be able to successfully confirm your appointments. If we cannot contact you do to inadequate contact information, your appointment will be considered confirmed and a *failed appointment charge* will be incurred if you do not appear at your scheduled time. If a message is left and not returned, or a response email is not received regarding confirmation, your appointment will be considered confirmed and a *failed* Austin General Dentistry, PLLC

*appointment charge* will be incurred if you do not appear at your scheduled time. After 2 failed appointments, we will no longer be obligated to appoint a scheduled time for your treatment.

#### LATE ARRIVAL

We understand that unexpected delays may occur when attempting to arrive at your appointment on time. We ask that you please contact the office as soon as possible to inform us of your late arrival. In an effort to see and treat all patients in a timely manner, appointments will be rescheduled for those arriving more than 15 minutes late. Consistent late arrivals will not be tolerated, and we will no longer be obligated to appoint a scheduled time for your treatment.

## **FINANCIAL POLICY**

All account balances are considered past due after 30 days. Should the balance not be paid within the allotted 30 day repayment period, a late charge of 1% of the balance will be added for each month the account is delinquent. A \$30.00 service fee will be added for any returned checks, and only advanced payment in cash or by credit card will be accepted for payment thereafter.

Initials\_\_\_\_\_

# **INSURANCE POLICY**

We are happy to accept insurance assignments if certain conditions are met: 1) the patient must satisfy his/her annual deductible, and 2) the patient understands that he/she is expected to pay for the estimated portion of the fee at the time of service, understanding also that is simply an *estimate*. If his/her insurance company does not pay in full for services within 60 days of treatment, the remaining balance will become the patient's responsibility. If the insurance payment does not meet the expected amount due, the patient is required to pay the remaining balance in full within 30 days. Should the balance not be paid within the allotted 30 day repayment period, a late charge of 1% of the balance will be added for each month the account is delinquent.

# ASSIGNMENT OF BENEFITS AGREEMENT

I understand that I am fully responsible for my account with Austin General Dentistry, PLLC. If my insurance benefits are denied, I will pay my account in full within 30 days. I understand that should my balance not be paid within the allotted 30 day repayment period, a late charge of 1% of the balance will be added for each month my account is delinquent. I understand that assignment of benefits is a courtesy extended to me by Austin General Dentistry, PLLC, and I will give my full cooperation until my account is paid in full.

**Agreement:** I, \_\_\_\_\_\_, have read and understand all of the above policies of Austin General Dentistry, PLLC, and I agree to their terms.

Name of Patient: \_\_\_\_\_\_

Signature of Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

### **GENERAL MEDIA RELEASE FORM**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_

Austin General Dentistry, PLLC

In connection with dental services and/or treatment being rendered, I give permission for photographs to be taken of me, with the following stipulations:

1) The photographs shall be taken by my dentist or licensed dental technician under the dentists' direction.

2) The photographs shall be used for medical records and/or as educational material as deemed appropriate by my dentist.

- 3) I will not be identified by name in association with the photographs other than for medical records purposes.
- 4) Photographs may be retouched in any way the professional staff considers desirable.

#### Please initial all that apply:

\_\_\_\_\_ I understand and hereby consent to the above.

\_\_\_\_\_ I give additional consent for my photos to be used for marketing purposes, including on the Austin General Dentistry website. I understand that my identity will not be disclosed without further consent.

\_\_\_\_\_ I understand that Austin General Dentistry promotes their practice through Social Media. I consent to the use of photographs of me engaging in day to day operations at Austin General Dentistry. I understand that I might be identified by first name only, and that my privacy will be protected as per HIPAA regulations.

Patient/Responsible Party Signature \_\_\_\_\_

Date: \_\_\_\_\_