PERSONAL HISTORY

Patient Name: _____ **Date:** _____

Address: _____

City/State: _____ **Zip Code:** _____

Sex: _____ **Marital Status (*circle one*):** S M D W **Spouse's Name:** _____

Date of Birth: ____/____/____ **Home Phone:** _____

Social Security Number: ____-____-_____ **Cellular Phone:** _____

Driver's License State/Number: _____ **Work Phone:** _____

Employer: _____ **Occupation:** _____

Employer Address: _____

City/State: _____ **Zip Code:** _____

Email address: _____

Emergency Contact: (Name) _____ **(Phone Number)** _____

Would you like to receive notifications from our office regarding appointments, treatment reminders, etc via EMAIL? Circle One Yes/No **via TEXT? Circle One** Yes/No

Referred By: _____

REASON FOR TODAY'S VISIT: _____

_____

FINANCIALLY RESPONSIBLE PERSON

(if other than patient)

Responsible Person: _____

Relationship to Patient: _____

Address: _____

City/State: _____ **Zip Code:** _____

Sex: _____ **Date of Birth:** ____/____/____ **Social Security Number:** ____-____-_____

Home Phone: _____ **Cellular Phone:** _____ **Work Phone:** _____

Driver's License State/Number: _____ **Email address:** _____

Would you like to receive notifications from our office regarding appointments, treatment reminders, etc via EMAIL? Circle One Yes/No **via TEXT? Circle One** Yes/No

Patient Medical History

Austin General Dentistry, PLLC

Patient Name:_____ **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.

Are you under a physician's care now?	Yes O No O	If yes please explain:_____
Have you ever been hospitalized or had a major operation?	Yes O No O	If yes please explain:_____
Have you ever had a serious head or neck injury?	Yes O No O	If yes please explain:_____
Are you taking any medications, pills, or drugs, including over the counter medication/vitamins?	Yes O No O	If yes please explain:_____
Do you take/have you taken, Phen-Fen/Redux?	Yes O No O	If yes please explain:_____
Do you, or have you ever taken medications containing bisphosphonates? (Fosamax, Boniva, Actonel)	Yes O No O	If yes please explain:_____
Do you use controlled substances?	Yes O No O	If yes please explain:_____
Do you use tobacco?	Yes O No O	If yes please explain:_____

Women Patients: Are you:

O Pregnant/Trying to get pregnant? O Nursing? O Taking oral contraceptives?

Are you allergic to any of the following?

O Aspirin	O Penicillin	O Codine	O Acrylic
O Metal/Nickel	O Latex	O Sulfa Drugs	O Local Anesthetics

Other? O If yes please explain:_____

Do you have, or have you had, any of the following:

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 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
Convulsions Yes O No O	Hemopilia Yes O No O	Radiation Treatments Yes O No O	Yellow Jaundice Yes O No O
COPD Yes O No O	Hepatitis A Yes O No O	Recent Weight Loss Yes O No O	

Have you ever had any serious illness not listed? Yes O No O If yes please explain:_____

Comments:

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.

X _____ Date:_____

Signature of Patient, Parent or Guardian

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.

Name of Patient: _____

Signature of Patient/Responsible Party: _____ 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.

CANCELLATION POLICY

If you are unable to keep an appointment, we kindly ask that you give our office at least 48 hours' notice to avoid a *failed appointment charge* of $50. We will make every attempt to contact you to confirm your appointment. Occasionally, we are only able to leave a message or are unable to contact you. We ask that you please be responsible for keeping your appointment.

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. If the insurance company does not pay 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, otherwise, 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**: _____