Texas Periodontal Associates

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Drivers License# _____ Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone Home: _____ Work: _____ Ext: _____ Cell: _____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

HEALTH INFORMATION

Date of Last Dental Visit: _____ Reason for visit with our office: _____

- My health is (circle) Excellent Good Fair Poor
- Date of the last exam: _____
- Do you or have you ever pre-medicated for dental visits? _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Congenital Heart
- ☐ Lesions
- ☐ CortisoneTreatment
- ☐ Cough
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ **Pregnancy** Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism Scarlet
- ☐ Fever Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

Name of physician: _____ Phone number: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
  _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
  _____
- Do you have any present or past serious illnesses? _____
  _____
- Are you taking any medications, including non-prescription medications? If yes, what medications are you taking?
  _____
  _____
  _____
- Do you smoke tobacco? ☐ Yes ☐ No
  How many packs/day? _____
- Do you drink alcohol? ☐ Yes ☐ No
  How many drinks/day? _____
- Do you use recreational drugs? ☐ Yes ☐ No
  If yes, what type and frequency? _____
- Are you ALLERGIC to or made sick by (ie. Itching, rash, swelling of hands/feet/eyes) penicillin, mycins, codeine, aspirin, or local anesthetics? ☐ Yes ☐ No
- Please list any surgical procedures you have had done, the date and if it was with general anesthesia or IV sedation. _____
  _____

WOMEN ONLY

- Are you using oral contraceptives? ☐ Yes ☐ No
- Have you reached menopause? ☐ Yes ☐ No
- Do you anticipate becoming pregnant within the next year? ☐ Yes ☐ No
- Do you experience yeast infections? ☐ Yes ☐ No

DENTAL INFORMATION

REFERRAL

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other

Name of person or office referring you to our practice: _____

PERIODONTAL HISTORY

- Do you avoid chewing or cleaning due to pain? ☐ Yes ☐ No
- Are you aware of clenching or grinding? ☐ Yes ☐ No
  Daytime or Nighttime?
- Do you have difficulty opening your mouth? ☐ Yes ☐ No
- Does your jaw click when opening or chewing? ☐ Yes ☐ No
- Do you gag easily? ☐ Yes ☐ No
- Have you experienced gum bleeding? ☐ Yes ☐ No
- Have you noticed bad breath? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment?
  If yes, please explain: _____
- Is this the first time you have had this problem? ☐ Yes ☐ No
  When did you become aware of your periodontal problem? _____
- Have you been treated for periodontal disease? ☐ Yes ☐ No
  Type of treatment: _____
- Has a member of your family been treated for periodontal disease? ☐ Yes ☐ No Who? _____

HYGIENE RECORD

- Brush ____ times a day with a (circle):
  Soft Medium Hard brush.
  Is it hand held or electric?
- Floss ____ times a day with (circle):
  Unwaxed Waxed Hand-held floss
- Brush and floss (circle):
  Morning Noon After dinner Bedtime

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient or guardian: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Juliet Yampey, Practice Manager
Telephone: (713) 457-6351 E-mail: jlyampey@texasperiodontal.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, (please print) _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature of patient or guardian: _____ Date: _____

PATIENT INFORMATION RELEASE CONSENT

Please list any person and their relationship to you with whom we may discuss your general dental conditions and diagnosis:

_____
_____
_____

Please list any person and their relationship to you with whom we may discuss your billing information, including account balance:

_____
_____
_____

You may leave messages (i.e. appointment reminders:

With others in my home:	☐ Yes	☐ No
On my answering machine at home:	☐ Yes	☐ No
With others at my work:	☐ Yes	☐ No
On my voicemail at work:	☐ Yes	☐ No
On my cell phone:	☐ Yes	☐ No

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The person responsible for payment is: ☐ self ☐ spouse ☐ other: _____

If you checked "spouse" or "other," please complete the following:

Name: _____ Birth Date: _____

Social Security #: _____ Phone (Home): _____ (Work): _____ Ext: _____

Address: _____

Street Apartment #

INSURANCE INFORMATION

Primary

Name of Insured: _____ Is the insured a patient here? ☐ Yes ☐ No

Insurance Plan Name: _____ Insured's Employer Name: _____

Insured's birth date: _____ ID #: _____ Group #: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary

Name of Insured: _____ Is the insured a patient here? Yes No

Last First MI

Insurance Plan Name: _____ Insured's Employer Name: _____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Patient's relationship to insured: ☐Self ☐Spouse ☐ Child ☐ Other

CONSENT FOR SERVICES

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

All dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged to the insurance company, however the patient is personally responsible for payment of all dental services. This office will prepare the patients insurance forms and assist in making collections from insurance companies. However, we are not a party to the contract between the patient and the insurance company and will not get involved in any disputes between the two parties except to supply factual information as needed. We do file claims as a courtesy to our patients but the patient is responsible for the balance on their account.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 where listed above to discuss matters related to this form.

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

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party