PATIENT INFORMATION

Note: the information on this form is necessary for our records. It is considered strictly confidential. Please complete all parts. Thank you.

Name: ______________________________ Date of Birth: ____________
Last First Middle Initial

Address: ______________________________ Email: ____________
Street City State Zip

Phone#: ______________________________
Home Cell Work

Social Security#: ______________ Drivers License#: ______________

Employer: ______________ Referred by: ______________

HEALTH INFORMATION

Last complete physical: __________ Physician: __________ Phone#: __________

Are you on any Medications?, If so, please list: ______________________________

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

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: __________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy
- ☐ OTHER __________
- ☐

Have you ever taken FOSAMAX, BONIVA, DIDIONEL, AREDIN, ACTONEL, SKELID, ZOMETA, BISPHOSPHONATE THERAPY? **YES NO**
(medications for Osteoporsis)

Are you on a blood thinner? __________ Have you had joint replacement therapy? ________ When: __________

DENTAL HISTORY

Date of Last dental visit: __________ Did you have x-rays? ________ Dental office/Phone#: __________

Are you dissatisfied with the appearance of your teeth? ________ Have you ever bleached your teeth? __________

Have you ever had gum or periodontal disease or treatment? ______________________________

Please add anything you feel is important for the doctor to know: ______________________________

THERE WILL BE A $30 CHARGE ON RETURNED CHECKS. DELINQUENT ACCOUNTS WILL BE TURNED OVER FOR COLLECTION.

Emergency Person: ______________________________ Phone# ______________

PERMIT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated, and I will assume responsibility for fees associated with those procedures. The above information is accurate to the best of my knowledge.

Patient/Parent Signature ______________________________ Date ______________

Policy of Payment

- Payment is due at the time service is performed
  We accept cash, checks (valid drivers license) and most major credit cards.

- Credit Cards accepted: MasterCard, Visa and Discover.

- We accept the Care Credit Card, which allows you to start treatment today and spread payments over time. Applying for the Care Credit Card only takes a few minutes and there is no fee to apply. Once the completed application is filled, we submit the information online. Immediately we will know if you have been approved and for what amounts.

- While we do not file secondary insurance, we are happy to help you file the 2nd claim.

- We are **IN-NETWORK** for many dental insurance plans. Please check With our insurance department to see if we are in-network with yours.

- We accept Dorsey Discount Service, however we cannot accept Dorsey & insurance at the same time. The patient will be allowed to use Dorsey here at the office and send in for reimbursement from their insurance on their own.

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy, we cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, we will assist you in an appeal, if needed. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.

- No show or missed appointments. When an appointment is scheduled with the doctor or at our facility, time is reserved specifically for you. When an appointment is not canceled 24 hours in advance, and the patient "no shows", another patient that needed to be seen may be denied the opportunity because the time slot was already taken. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call. **If a 24 hour notice of cancellation is not given, you will be charged a $35.00 fee.**

____
Initial

I have read and have a full understanding of the financial policies of Alvin Dental Care.

Patient Signature ______________________________ Date __________
Or
Guarantor Signature ______________________________ Date __________

ALVIN DENTAL CARE

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you do not understand.

The recommended treatment or alternate treatment is necessary to attain dental health. Some treatment plans requires a watchful waiting. However in most cases no dental treatment or delayed dental treatment may result in dental decay, infections, loss of bone, gum recession, bad breath, inability to perform adequate oral hygiene, loosening of teeth, tooth movement or tooth loss.

There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or premedication prior to dental care being rendered. Some of these risks/complications are/ but not limited to, the following:

Sensitivity & pain
Infection
Infection to adjacent tooth and/or
Hard or soft tissue
Bleeding
Dry socket
Incomplete removal of tooth
Injury to adjacent structures
Allergic reaction to drugs
Tooth or fragment in maxillary sinus
Perforation of roots by instrument
Swallowing and/or aspiration of objects
Discoloration of tooth
Gum recession
Tooth mobility
Food impaction
Continued periodontal disease
Failure of treatment to accomplish its purpose
Trismus (jaw pain or difficulty opening mouth)
Fracture of mandible (lower jaw) or maxilla (upper jaw)
Paresthesia or numbness of tongue, and/or mouth, and/or face
Slough-necrosis (unanticipated loss of hard and/or soft tissue)
Opening between mouth and sinus or mouth and nose

Swelling & bruising
Drowsiness
Nausea & Vomiting
Syncope (Fainting)
Failure of wound to heal
Loss of teeth
Loss of bone
Instrument breakage
Bacterial Endocarditis
Breakage of root(s)
Retained root fragments
Injury to jaw joint
Change in occlusion (bite)
Speaking difficulties
Nerve problems
Root staining
Implant rejection

Additional oral surgery, hospitalization and/or further treatment may be required in the event of complication(s).

ACKNOWLEDGEMENT

I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this consent form. I was given an adequate opportunity to ask questions and all questions that were asked were answered to my satisfaction.

I also understand that the proposed treatment plan contains no guarantee, or warranty of success. Each individual case is unpredictable, making it impossible to surmise results. I further understand that the results may not be to my complete and full satisfaction after the treatment and that my condition may be the same, better or worse after treatment.

I hereby authorize and direct the dentist and/or associates, hygienist, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid unless revoked by me in writing.

Patient Name: ______________________________

Signature of Patient or Guardian: ______________________________

DATE: ______________________________

ALVIN DENTAL CARE

Raymond B. Fournier D.D.S.
1701 Fairway Plaza, Ste 20 Alvin, TX 77511 | **281-331-0020**

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

______________________________ Please ***print*** name of Patient

______________________________ Please ***sign*** for Patient / Guardian of Patient

______________________________ Legal Representative / Guardian

______________________________ Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ______________________________
____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Informal Name ________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ________________________ Relationship: ____________________________

Name: ________________________ Relationship: ____________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone: __________________
☐ Home Phone: __________________
☐ Work Phone: __________________
☐ **Any of the Above**
☐ Text Message to my Cell Phone
☐ Email: ______________________________
☐ Postcard

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone
☐ Home Phone
☐ Work Phone
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

____
Signature of Privacy Officer