

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.

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

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

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 _____



ALVIN DENTAL CARE

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, American Express 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 Thrive Dental Plan, however we cannot accept Thrive & insurance at the same time. The patient will be allowed to use Thrive 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 \$25.00 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	Swelling & bruising
Infection	Drowsiness
Infection to adjacent tooth and/or	Nausea & Vomiting
Hard or soft tissue	Syncope (Fainting)
Bleeding	Failure of wound to heal
Dry socket	Loss of teeth
Incomplete removal of tooth	Loss of bone
Injury to adjacent structures	Instrument breakage
Allergic reaction to drugs	Bacterial Endocarditis
Tooth or fragment in maxillary sinus	Breakage of root(s)
Perforation of roots by instrument	Retained root fragments
Swallowing and/or aspiration of objects	Injury to jaw joint
Discoloration of tooth	Change in occlusion (bite)
Gum recession	Speaking difficulties
Tooth mobility	Nerve problems
Food impaction	Root staining
Continued periodontal disease	Implant rejection
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	

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
1701 Fairway Drive, Ste. 20
Alvin, Texas 77511

**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 (Patient or Guardian of Patient)

Name of Legal Representative/Guardian

Relationship of Legal representative/Guardian to patient

Your comments regarding Acknowledgements of Consent: _____

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

First Name only Only by Last Name Informal Name _____

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

Cell Phone _____ Text message to my cell phone

Home Phone : _____ Email: _____

Work Phone: _____

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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