DRIPPING SPRINGS FAMILY DENTISTRY

Name:____________________ **Medical Health History** **BP:**_____________________

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

Heart Problems

Chest Pain	Y	N
Shortness of Breath	Y	N
Blood Pressure Problems	Y	N
Heart Murmur	Y	N
Taking Heart Medication	Y	N
Rheumatic Fever	Y	N
Pacemaker	Y	N
Artificial Heart Valve	Y	N

Blood Problems

Easy Bruising	Y	N
Frequent Nosebleeds	Y	N
Abnormal Bleeding	Y	N
Blood Disease (anemia)	Y	N
Ever Require Blood Transfusion	Y	N

Allergy Problems

Hay Fever	Y	N
Sinus Problems	Y	N
Skin Rashes	Y	N
Taking Allergy Medication	Y	N
Asthma	Y	N

Intestinal Problems

Ulcers	Y	N
Weight Gain	Y	N
Special Diet	Y	N
Constipation/Diarrhea	Y	N
Kidney or Bladder Problems	Y	N

Bone or Joint Problems

Arthritis	Y	N
Back or Neck Pain	Y	N
Joint Replacement (e.g., total hip, pins, or implants)	Y	N

Strokes	Y	N
Frequent or Severe Headaches	Y	N
Thyroid Problems	Y	N
Persistent Cough or Swollen Glands	Y	N
Premedication's Required by Physician	Y	N
Cancer/Tumor	Y	N

Are you Allergic, or have you reacted adversely, to any of the following?

Local Anesthetics ("Novocaine")	Y	N
Penicillin or other Antibiotics	Y	N
Sulfa Drugs	Y	N
Barbiturates, Sedations, or Sleeping Pills	Y	N
Latex	Y	N

Notes (Other allergies):______________________

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Diabetes

Urinate more than 6 times a day	Y	N
Thirsty or mouth is dry much of the time	Y	N
Family History of Diabetes	Y	N
Tuberculosis or Other Respiratory Disease	Y	N
History of Alcohol or Drug Abuse?	Y	N
Do you drink Alcohol?	Y	N

If so how much? ________________________

Do You Smoke?	Y	N

If so, how much? ________________________

Hepatitis, Jaundice, or Liver Trouble	Y	N
Herpes or other STD	Y	N
HIV-Positive/AIDS	Y	N
Glaucoma	Y	N
Do you wear contact lenses?	Y	N
History of Head Injury	Y	N
Epilepsy or other neurological Disease?	Y	N

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _________________________________

____

During the past 12 months, have you taken any of the Following?

Antibiotics or Sulfa Drugs	Y	N
Anticoagulants (e.g., Coumadin)	Y	N
High Blood Pressure Medicine	Y	N
Tranquilizers	Y	N
Insulin, Orinase, or similar drug	Y	N
Aspirin	Y	N
Digitals or drugs for heart trouble	Y	N
Nitroglycerin	Y	N
Cortisone (Steroids)	Y	N
Natural Remedies	Y	N
Nonprescription drugs/supplements	Y	N

List medications that you take: _____________________________

____

Women

Are you taking contraceptives or other hormones?	Y	N
Are You Pregnant?	Y	N

If so, expected delivery date: ________________________

Are you Nursing?	Y	N
Have you reached Menopause?	Y	N

If so, do you have any symptoms? __________________

____

Notes: ____

____

Change in Phone Number or Address: Y N

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Patient Signature: ___________________________ **Date:** ____________________

~Welcome~

Dripping Springs Family Dentistry, Inc.

Proudly serving Dripping Springs and Surrounding Communities for over 15 years!

Patient Information (CONFIDENTIAL)

Name ____ DOB____________SS#_____________________

Address ____________________________________City _________________ State ____ Zip Code ______

Email __________________________________Cell Phone _______________

Please circle: Male/Female Minor/Single/ Married/ Divorced/ Widowed/ Separated

Emergency Contact Name: _______________________Phone_____________Relationship___________

Whom me we thank for referring you?____

Insurance Information

Primary Insurance Information

Name of Insured ___________________________Cell Phone_____________Relation to Patient_______

Insured's Address ____________________________City _____________ State______Zip Code ________

SS# ________________ DOB__________Name of Employer_____________________________________

Address of Employer _______________________________City_____________State____Zip Code______

Insurance Company _______________________Group# _______**Sub/Member ID#/**________________

Ins. Co. Address ____________________________City _______________ State ___ Zip Code_________

Secondary Insurance Information

Name of Insured ___________________________Cell Phone_____________Relation to Patient_______

Insured's Address ____________________________City _____________ State______Zip Code ________

SS# ________________ DOB__________Name of Employer_____________________________________

Address of Employer _______________________________City_____________State____Zip Code______

Insurance Company _______________________Group# _______**Sub/Member ID#/**________________

Ins. Co. Address ____________________________City _______________ State ___ Zip Code_________

Responsible Party

Name_____________________________ Birth date __________ Relation to Patient ______________________

Address ____________________________________City _____________ State______Zip Code ________

Cell Phone ___________________ Work Phone_________________Email ____________________________

Employer Name:__________________________Occupation_______________________________

Address ____________________________________City _____________ State______Zip Code ________

Patient Dental History

Name of Previous Dentist and Location ________________________________Date of Last Exam ___________

Please circle yes or no to the following questions:

Do your gums bleed while brushing or flossing? Yes/No **Do you have frequent headaches?** Yes/No

Are your teeth sensitive to hot or cold liquids/foods? Yes/No

Are your teeth sensitive to sweet or sour liquids/foods? Yes/No

Do you feel pain to any of your teeth? Yes/No

Do you have any sores or lumps in or near your mouth? Yes/No

Have you had any head, neck or jaw injuries? Yes/No If yes please explain_____________________________________

Have you ever experienced any of the following problems in your jaw?

Clicking Yes/No **Pain** (joint, ear, side of face) Yes/No **Difficulty in opening or closing** Yes/No **Difficulty in chewing** Yes/No

Do you clench or grind your teeth? Yes/No **Do you bite your lips or cheeks frequently?** Yes/No

Have you ever had any difficult extractions in the past? Yes/No

Have you ever had any prolonged bleeding following extractions? Yes/No

Have you had any orthodontic treatment (braces)? Yes/No

Do you wear dentures or partials? Yes/No If yes, date of placement _____________________

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes/No

Do you like your smile? Yes/No If no please explain____

Authorization and Release I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Guardian X____ Date ________________

Dripping Springs Family Dentistry, Inc.
Financial Policy

Proudly serving Dripping Springs and Surrounding Communities for over 15 years!

We value you as a patient and are committed to providing you with the best possible dental care. We want you to have complete understanding of your financial responsibilities for the services we provide. To assist us in achieving these goals, we ask that you review our financial policy.

Unless our authorized staff has approved payment arrangements in advance, payment in full will be due at the time services are rendered. We will be happy to help process your claim for reimbursement or you may assign your primary insurance benefits to the doctor for partial payment towards the services rendered. This can be done after we have had the opportunity to verify your primary insurance benefits.

At the time of the appointment, you will be expected to pay your deductible as well as any portion of the treatment fees that we ESTIMATE will not be covered by your insurance policy. Because of insurance policy changes and/or necessary changes in treatment plans, your dental coverage may vary from a treatment calculation or your carrier's pre-estimate. If your insurance company has not paid the full balance of the claim within 60 days from the treatment date, you will be responsible for paying the balance. **Please remember that your insurance is a contract between you and your insurance company and/or employer. Our dental practice is not a party to the contract.** We recommend that any questions regarding the amount of insurance coverage for the specific treatment be discussed with your insurance company or your employer.

If your check is dishonored or returned for any reason there will be a **$45.00** processing fee. Your payment by check is your acceptance of this agreement and its terms.

We do understand when emergencies surface and you need to cancel an appointment. We request that when you do cancel, you give at least **48 hours of notice**. Please understand that if you cancel or "no show" on two consecutive visits, we will charge your account **$45.00.**

All treatment charges are the responsibility of the patient or responsible party regardless of insurance coverage. In the event of non-payment, the patient or responsible party agrees to pay all the costs of collection including but not limited to attorney fees, court costs, collection agency fees, etc.

I have read and understand the financial policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient/Parent/ Guardian ________________________Date_____________