HEALTH HISTORY

Date _____ **Patient Name** _____ **Name you wish to be called** _____
Physical Address _____ **Home Phone** _____
City _____ **State** _____ **Zip Code** _____ **Work Phone** _____
Mailing Address _____
City _____ **State** _____ **Zip Code** _____
Best Time and Place to Reach You _____ **Email** _____
Sex: ٱ **M** ٱ **F** **Age** _____ **Birthdate** _____ ٱ **Single** ٱ **Married** ٱ **Widowed** ٱ **Separated** ٱ **Divorced** ٱ **Domestic Partner**
Patient SS # _____ **Occupation** _____ **Employer** _____
Employer Address _____ **Employer Phone** _____
Spouse Name _____ **Birthdate** _____ **SS#** _____
Occupation _____ **Spouse's Employer** _____

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IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
Name _____ **Relationship to you** _____
Address and Phone Number of Emergency Contact Person _____
Whom may we thank for referring you? _____
Who is responsible for this account? _____ **Relationship to patient** _____

****

Insurance Company _____ **Group #** _____
Is patient covered by additional insurance? ٱ **yes** ٱ **no Subscriber's name** _____
Subscriber's Birthdate _____ **Subscriber's SS#** _____ **Relationship to Patient** _____
Insurance company _____ **Group #** _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ **and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.**

_____ _____ _____
Responsible Party Signature **Relationship** **Date**

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DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ **City/State** _____
Date of last dental visit _____ **Date of last dental X-rays** _____
Please check Yes or No to indicate if you have had any of the following:

Bad breath	ٱ **Yes** ٱ **No**	**Bleeding gums**	ٱ **Yes** ٱ **No**	**Blisters on lips or mouth**	ٱ **Yes** ٱ **No**
Burning sensation on tongue	ٱ **Yes** ٱ **No**	**Chew on one side of mouth**	ٱ **Yes** ٱ **No**	**Cigarette, pipe or cigar smoking**	ٱ **Yes** ٱ **No**
Clicking or popping Jaw	ٱ **Yes** ٱ **No**	**Dry mouth**	ٱ **Yes** ٱ **No**	**Fingernail biting**	ٱ **Yes** ٱ **No**
Do you or have you ever experienced pain/discomfort in your jaw joint	ف **Yes** ف **No**	**Food collection between teeth**		**Chewing tobacco**	ٱ **Yes** ٱ **No**
Food collection tender	ٱ **Yes** ٱ **No**	**Foreign objects**	ٱ **Yes** ٱ **No**	**Grinding teeth**	ٱ **Yes** ٱ **No**
Periodontal	ٱ **Yes** ٱ **No**	**Jaw pain or tiredness**	ٱ **Yes** ٱ **No**	**Lip or cheek biting**	ٱ **Yes** ٱ **No**
Loose teeth or broken fillings	ٱ **Yes** ٱ **No**	**Mouth breathing**	ٱ **Yes** ٱ **No**	**Orthodontic treatment**	ٱ **Yes** ٱ **No**
Pain around ear	ٱ **Yes** ٱ **No**	**Sensitivity to cold treatment**	ٱ **Yes** ٱ **No**	**Gums swollen or**	ٱ **Yes** ٱ **No**
Sensitivity to heat	ٱ **Yes** ٱ **No**	**Sensitivity to sweets**	ٱ **Yes** ٱ **No**	**Sensitivity when biting**	ٱ **Yes** ٱ **No**
Sores or growths in your mouth	ٱ **Yes** ٱ **No**	**How often do you floss** _____		**Do you like your smile**	ٱ **Yes** ٱ **No**
		How often do you brush?_____		**Type of bristles** ف**Hard** ف**Medium** ف**So**ft	
				Have you ever had a serious or difficult problem associated with previous dental work	ٱ **Yes** ٱ **No**

MEDICAL HISTORY

Physician's Name _____ **Date of last visit** _____

Please check yes or no to indicate if you have had any of the following:

AIDS	¡ Yes ¡ No	**Epilepsy**	¡ Yes ¡ No	**Psychiatric Care**	¡ Yes ¡ No
Anemia	¡ Yes ¡ No	**Fainting or dizziness**	¡ Yes ¡ No	**Radiation Treatment**	¡ Yes ¡ No
Arthritis, Rheumatism	¡ Yes ¡ No	**Glaucoma**	¡ Yes ¡ No	**Respiratory Disease**	¡ Yes ¡ No
		Headaches	¡ Yes ¡ No	**Rheumatic Fever**	¡ Yes ¡ No
Artificial heart valves	¡ Yes ¡ No	**Heart Murmur**	¡ Yes ¡ No	**Scarlet Fever**	¡ Yes ¡ No
		Heart Problems	¡ Yes ¡ No	**Shortness of Breath**	¡ Yes ¡ No
Artificial Joints	¡ Yes ¡ No	**Hepatitis**	¡ Yes ¡ No	**Sinus Trouble**	¡ Yes ¡ No
Asthma	¡ Yes ¡ No	**Type** _____		**Skin Rash**	¡ Yes ¡ No
Back Problems	¡ Yes ¡ No	**Herpes**	¡ Yes ¡ No	**Special Diet**	¡ Yes ¡ No
Bleeding abnormally (with extractions or surgery)	¡ Yes ¡ No	**High Blood Pressure Meds:** _____	¡ Yes ¡ No	**Stroke**	¡ Yes ¡ No
	¡ Yes ¡ No	**HIV Positive**	¡ Yes ¡ No	**Swelling of Feet or ankles**	¡ Yes ¡ No
Blood Disease	¡ Yes ¡ No	**Jaundice**	¡ Yes ¡ No	**Swollen Neck Glands**	¡ Yes ¡ No
Cancer	¡ Yes ¡ No	**Jaw Pain**	¡ Yes ¡ No	**Thyroid Problems**	¡ Yes ¡ No
Chemical dependency	¡ Yes ¡ No	**Joint replacement**	¡ Yes ¡ No	**Tonsillitis**	¡ Yes ¡ No
Chemotherapy	¡ Yes ¡ No	**Kidney Disease**	¡ Yes ¡ No	**Tuberculosis**	¡ Yes ¡ No
Circulatory problems	¡ Yes ¡ No	**Liver Disease**	¡ Yes ¡ No	**Tumor or growth on Head or Neck**	¡ Yes ¡ No
		Low Blood Pressure	¡ Yes ¡ No		
Congenital Heart Lesions	¡ Yes ¡ No	**Mitral Valve Prolapse**	¡ Yes ¡ No	**Ulcer**	¡ Yes ¡ No
		Nervous Problems	¡ Yes ¡ No	**Venereal Disease**	¡ Yes ¡ No
Cortisone treatments	¡ Yes ¡ No	**Pacemaker**	¡ Yes ¡ No	**Weight Loss, unexplained**	¡ Yes ¡ No
		Women:			
Cough, Persistent or bloody	¡ Yes ¡ No	**Are you pregnant?**	¡ Yes ¡ No	**Any hospital stays**	¡ Yes ¡ No
		Due date _____		**Explain** _____	
Diabetes	¡ Yes ¡ No	**Are you nursing?**	¡ Yes ¡ No	_____	
Do you wear Contact lenses	¡ Yes ¡ No	**Are you taking birth control pills?**	¡ Yes ¡ No	_____	

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MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

¡ **Aspirin**
¡ **Barbiturates (sleeping pills)**
¡ **Codeine**
¡ **Iodine**
¡ **Latex**
¡ **Local Anesthetic**
¡ **Penicillin**
¡ **Sulfa**
¡ **Other** _____

_____

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an agreement between me and my insurance company.

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____

Patient's Signature **Date**

_____ _____

Doctor's Signature **Date**

(I have read, agree to, and understand the statements listed above)

Onion Creek Family Dentistry
11215 South I-35, Suite #116
Austin, Texas 78747

OUR FINANCIAL POLICY & NOTICE OF PRIVACY PRACTICES

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

We accept cash, check, MasterCard, Visa, American Express, and Discover as payment for services rendered. We ask our guests for payment for routine services at the time of your visit. Due to the costs of laboratory fees and billing, extended payment plans cannot be arranged through the office.

As a courtesy to you, we will file your insurance for dental treatment. The estimated insurance portion is only an estimate of what your insurance may pay. After 30 days if insurance has not paid their estimated portion the remaining balance is the patient's responsibility. The deductible, co- payment, and any other charges are to be paid at the time of services. Treatment options may change during the course of treatment as deemed necessary by the doctor and additional fees may apply. I understand that this is only as estimate of dental benefits covered by my insurance and that I am responsible for what my insurance does not pay. However, if your insurance routinely sends your checks to you, then we ask for payment in full at the time of service. ***Insurance is a contract between you and your insurance company; therefore, you are still responsible for the timely payment of your account in the event the insurance company does not cover the cost of treatment.***

There will be a $35.00 service charge for all returned checks.
There will also be a $50.00 fee for missed appointments without 24 hour notice.
Accounts turned over to a collection agency will be reported to NCO Credit Bureau.
Thank you for your understanding of our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____

Date _____

Notice of Privacy Practices:
By signing this office policy you also state that you have read the Notice of Privacy Practices. You can obtain a paper copy of this notice upon request.

Responsible Party Signature _____

Date _____