Patient Information

Patient ___married ___single ___minor ___male ___female **Date:** _____

Name: _____ **Date of Birth:** _____
Last First M

Address: _____
Street city state zip

Telephone: _____
Home Work Cell email

Drivers License #: _____ **Social Security #:** _____

Employer/School: _____ **Address/grade:** _____

Who referred you to our office: _____

Wife/Mother

Name: _____ **DOB:** _____ **SSN:** _____
Last First M

Address: _____
Street city state zip

Telephone: _____
Home Work Cell email

Employer: _____ **Address:** _____

Husband/Father

Name: _____ **DOB:** _____ **SSN:** _____
Last First M

Address: _____
Street city state zip

Telephone: _____
Home Work Cell email

Employer: _____ **Address:** _____

Emergency Contact: _____
Name Phone number

Method of Payment

Responsible party currently has an account with this office	**YES**	**NO**
Payment in full at each appointment by cash or personal check.	**YES**	**NO**
Payment in full at each appointment by Visa, Mastercard, or other	**YES**	**NO**
I wish to discuss the Dental Office's Financial Policy	**YES**	**NO**

Authorization

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medication and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental and medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third-party payors and/or other health professionals by any method, including electronic transfer.

Patient Signature: _____ **Date** _____

Name: _____ Date: _____

Dental and Medical History

Primary Reason for visit: _____

Dental History

Do you have dental examinations on a routine basis? Date of last visit _____	Y	N
Do you think you have active decay or gum disease? _____	Y	N
Do your gums ever bleed? Discuss _____	Y	N
Do you have any concerns about your smile? _____	Y	N
Do you experience popping or discomfort in your jaw? _____	Y	N
Do you experience frequent headaches or jaw muscle soreness? _____	Y	N
Do you smoke or chew tobacco? _____	Y	N

How often do you brush _____ Floss _____

Name of previous dentist _____ Date of last x-rays _____

Medical History

Are you under a physician's care now? Why _____ Who _____	Y	N
Have you ever been hospitalized or had a major operation? _____	Y	N
Have you had any change to your general health in the last year? _____	Y	N
Have you ever been told you need antibiotics prior to dental treatment? _____	Y	N
Are you allergic to any medicines/latex/metals/acrylics? _____	Y	N

What medicines/vitamins are you currently taking? _____

_____

Women, are you: Pregnant or trying Nursing Taking oral contraceptives

Do you now or have you ever had any of the following?

Heart disease/surgery	Y	N	Heart Murmur	Y	N	Cancer	Y	N
Heart attack/failure	Y	N	Chest Pain	Y	N	Anemia	Y	N
Congenital heart disease	Y	N	Heart Pace Maker	Y	N	Diabetes	Y	N
Mitral Valve Prolapse	Y	N	High Blood Pressure	Y	N	Ulcers	Y	N
Bacterial Endocarditis	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Excessive Bleeding	Y	N	Blood thinners	Y	N	Asthma	Y	N
Artificial heart valves	Y	N	Swelling of Limbs	Y	N	Emphysema	Y	N
Osteonecrosis of jaw	Y	N	Lung disease	Y	N	Tuberculosis	Y	N
Bisphosphonates	Y	N	Breathing problems.	Y	N	Radiation	Y	N
Fosamax, Actonel, Boniva	Y	N	Aredia/Zometa I.V	Y	N	Epilepsy	Y	N
Stomach/intestinal disease	Y	N	Chemotherapy	Y	N	Seizures	Y	N
Hepatitis A, B, or C	Y	N	Liver disease	Y	N	Fainting	Y	N
Thyroid disease	Y	N	Kidney problems	Y	N	Dizziness	Y	N
Cortisone medicine	Y	N	Parathyroid disease	Y	N	Arthritis	Y	N
Artificial Joint	Y	N	Rheumatism	Y	N	AIDS/HIV	Y	N
Herpes	Y	N	Venereal Disease	Y	N	Alcoholism	Y	N
Tattoos/Body piercing	Y	N	Drug Addiction	Y	N	Nervousness	Y	N
Alzheimer's disease	Y	N	Fever Blister	Y	N	Hives/Rash	Y	N
Psychiatric Care	Y	N	Tumors/growths	Y	N	Allergies	Y	N

Have you ever had any other illness not checked above? _____ Y N

To the best of my knowledge the preceding answers are correct. If there are any changes to my health status or if my medicines change I shall inform the dentist and staff at the next appointment without fail.

Patient signature _____ Date _____

Reviewed by Doctor _____ Date _____ BP _____ Pulse _____

History review and significant findings _____

BRANDON K. FLORENCE, D.D.S.
207 W. Belt Line Rd.
Cedar Hill, TX 75104

Consent for Insurance Release

We are committed to protecting your confidentiality and right to privacy. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to obtain consent from you prior to releasing any information to your insurance agency. If you desire for us to prepare your insurance claim and ready it for mailing for you, we need your consent. This will also permit us to respond to requests by your insurance company for explanation of treatment necessity or radiograph duplication and forwarding. Both are common requests by insurance companies necessary to complete claim processing and reimbursement.

Please understand this in no way allows for us to release any information regarding you or your treatment to any contractors, employers, government agencies, or any other third parties, except when stipulated by law. This is a strict statement regarding provision of information to your insurance company for processing your claim for reimbursement.

_____ _____

Patient Signature Date

Insurance Information

Primary Insurance _____

Address _____

City _____ State _____ Zip ____

Phone # _____

Insured Name _____

Insured SSN _____

Insured DOB _____ Insured ID# _____

Employer _____

Insured's Relationship to Patient _____

If patient is over 18, is patient a student? _____

If so, where? _____

Primary Insurance _____

Address _____

City _____ State _____ Zip ____

Phone # _____

Insured Name _____

Insured SSN _____

Insured DOB _____ Insured ID# _____

Employer _____

Insured's Relationship to Patient _____

If patient is over 18, is patient a student? _____

If so, where? _____

Financial Responsibility / Waiver Form

Dear Patient:

Positive verification of your coverage cannot always be made at the time of service. You will receive services with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for these services rendered.

Patient's Name | Insurance Carrier

Subscriber's Name | Employer / Group

Permanent Address | Group Policy Number

City, State, Zip | Telephone Number

I have read the above and understand my possible financial responsibility of services rendered and hereby affix my signature as an acknowledgment of this understanding.

Patient's Signature | Date

Witness Signature | Date

Place a copy of patient's driver's license below if not on file in chart.

Patient Understanding and Informed Consent

Consent to Dental Procedures: Before receiving treatment you should ask the dentist about the procedure(s) that he recommends you undergo, and ask any questions you may have before you decide whether or not to give your consent for the procedure(s) to be done. All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result or cure. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risk of no treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance.

X-rays: Dental radiographs will be made as necessary and appropriate for examinations, diagnosis, consultation, and treatment.

Drugs and Medications: Antibiotics, analgesics, and other medication can cause reactions such as redness and swollen tissue, pain, itching, vomiting and or anaphylactic shock.

Fillings: Care must be taken when chewing on filled teeth, especially in the first 24 hours, to avoid breakage. Teeth with new fillings can be sensitive for a short time after being placed.

Crown and Bridge: Sometimes it is difficult to match artificial teeth to the natural teeth. After preparing teeth for crown and bridge, a temporary will be placed which can come off easily. Care should be taken to ensure the temporary stays in place until the seating of the permanent restoration. If for some reason the temporary breaks or is loosened you should notify our office immediately. The final opportunity to make changes (shape, fit, size, color) is before final cementation of permanent restoration. Excessive delay to return for permanent crown should be avoided, for with time, the teeth can shift, making it difficult to fit the new restoration properly.

Partials and Dentures: Wearing partials and dentures can be difficult. Sore spots, altered speech, and difficulty eating are common problems. Immediate dentures (dentures placed immediately after extractions) can be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed at a later date. This is not included in the denture fee. It is your responsibility to return for delivery of your partial/denture in a timely manner or the result may be an ill-fitting denture.

Occasionally, a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decay. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I request and authorize.

Patient / Guardian _____ Date _____

Staff _____ Date _____

Brandon K. Florence, D.D.S., P.L.L.C.
207 W. Belt Line
Cedar Hill, Texas 75104

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement"

I, _____, have read a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgment

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

_____

_____

_____

Brandon K. Florence, D.D.S., P.L.L.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security #: _____

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 encourage you to read it carefully and completely before signing 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: Pam Lamar

Telephone: 972-291-1501 Fax: 972-291-1503

Address: 207 W. Belt Line Road Cedar Hill, Texas 75104

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.

SIGNATURE

I,_____, 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 health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.