Family Dental Care

COSMETIC & FAMILY DENTISTRY

16000 Stuebner Airline # 230 · Spring, TX 77379
Ph: 281.376.9068 · Fax: 281.251.4350

Please Check One: ☐ Adult ☐ Child

PATIENT'S INFORMATION

Patient's Name: (Last, First, MI)	Sex: ☐ M ☐ F	Birth date:	Age:

If Patient is a minor, give parent's or guardian's name:	Today's Date:

Who may we thank for referring you to your office?	How did you find out about us?	Reason for this visit?

Physician Name:	Physician Address:	Physician Phone #:

Patient or Self Information:	Marital Status:

Address: (Street, City, State, Zip Code)	E-mail:	May we e-mail you about appointment? ☐ Y ☐ N

How long at this address?	Home Phone:	Cell Phone:	May we text you about appointment? ☐ Y ☐ N	Work Phone:	What is the best way to contact you?

Social Security #:	Birth Date:	Driver's License No:	Relation to Patient:

Employer:	Occupation:	No. of years employed:

SPOUSE INFORMATION (IF APPLIES)

Name: (Last, First, MI)	Birth Date:	Social Security #:

Employer:	Occupation:

No. Years Employed:	Work Phone:	Cell Phone:

DENTAL INSURANCE INFORMATION (Primary Carrier)

INSURED PERSON'S NAME:	BIRTH DATE:

INSURANCE COMPANY:

INSURED'S EMPLOYER:

INSURED'S SOCIAL SECURITY NO:	GROUP NO:

PATIENT SIGNATURE:	DATE:

Family Dental Care

COSMETIC & FAMILY DENTISTRY
16000 Stuebner Airline # 230 · Spring, TX 77379
Ph: 281.376.9068 · Fax: 281.251.4350

MEDICAL HISTORY

	YES	NO
1. Asthma, Hay fever, sinusitis, or other allergies (Please circle)	☐	☐
2. Allergy to penicillin, aspirin, local or general anesthetic, or other drugs:? Allergies to anything else? Specify: 1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____ 7. ____ 8. ____ 9. ____	☐	☐
3. Rheumatic fever or heart murmur or mitral valve prolapse (Please circle)	☐	☐
4. A pacemaker or open heart surgery or heart valve replacement (Please circle)	☐	☐
5. Diabetes, Liver, Kidney, Thyroid or lung problems (Please circle)	☐	☐
6. Arthritis or hip replacement surgery or prosthetic joint replacement (Please circle)	☐	☐
7. Please list any medications you are currently on: 1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____ 7. ____ 8. ____ 9. ____ If you are on many medications, please make list and attach to the page.		
8. Communicable disease: Tuberculosis, Herpes or venereal (Please circle)	☐	☐
9. Acquired Immune Deficiency Syndrome (AIDS), A.R.C. or HIV positive (Please circle)	☐	☐
10. Do any wounds heal slowly or present complications?	☐	☐

	YES	NO
11. Have you ever been hospitalized? Date/Reason: ____ Date/Reason: ____ Date/Reason: ____	☐	☐
12. Blood pressure or heart problems (Please circle)	☐	☐
13. Ulcer or stomach problems (Please circle)	☐	☐
14. Hepatitis or jaundice (Please circle)	☐	☐
15. Epilepsy or nervous disorders (Please circle)	☐	☐
16. Bleeding or clotting disorders (Please circle)		
17. Any other illness ____	☐	☐
18. When was your last physical exam? Date: ____	☐	☐
19. Are you presently under the care of a physician?	☐	☐
20. Have you had chemotherapy?	☐	☐
21. Are you presently on a diet?	☐	☐
22. Women - Are you taking birth control pills?	☐	☐
23. Women - Are you pregnant?	☐	☐
	☐	☐
	☐	☐

DENTAL HISTORY

	YES	NO
1. Is there anything you would like to change about the appearance of your teeth?	☐	☐
2. Have you had trouble from previous dental care?	☐	☐
3. Do you have pain in your jaw or near your ears?	☐	☐
4. Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
5. Have you experienced any growths or sore spots in your mouth?	☐	☐
6. Does any part of your mouth hurt when clenched?	☐	☐
7. Have you ever had Novocaine or other local anesthetic?	☐	☐
8. Have you ever had Nitrous Oxide (laughing gas)?	☐	☐
9. Have you ever had general anesthesia?	☐	☐
10. Have you ever had any reaction or allergic symptoms to Novocaine, local or general anesthetics	☐	☐
11. Have you ever had a difficult extraction in the past?	☐	☐
12. Have you ever had prolonged bleeding following extraction in the past?	☐	☐
13. Do your gums bleed?	☐	☐
14. Do you have a bad taste in your mouth or mouth odor?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐
16. Do you chew on only one side of your mouth? If so, why?	☐	☐
17. Do you habitually clench or grind your teeth during the night or day?	☐	☐
18. Is any part of your mouth sensitive to pressures or irritants (hot, cold, or sweets)?	☐	☐
19. Any other concerns you wish to discuss today?	☐	☐

PATIENT/PARENT/GUARDIAN SIGNATURE	DOCTOR SIGNATURE	DATE

Family Dental Care
COSMETIC & FAMILY DENTISTRY
16000 Stuebner Airline # 230 · Spring, TX 77379
Ph: 281.376.9068 · Fax: 281.251.4350

CONSENT TO DISCLOSE PRIVATE HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, AND/OR HEALTH CARE OPERATIONS

I, ________________________________, social security number ____________________________, date of birth ________________________________, hereby authorize and consent for FAMILY DENTAL CARE (Jay K. Doshi Dental Associates, P.A.) to release any and all medical/dental notes, physician narratives, office notes, discharge summaries, doctor(s)/dentist(s) orders, lab reports, progress notes, x-rays, and any other information contained therein, any documents and opinions relevant to past, present or future physical and mental condition, treatment, care or hospitalizations, and any other personal health information regarding my medical/dental care as necessary to carry out treatment, obtain payment, and/or conduct other health care operations.

The release of the matters listed above is being authorized for purposes of obtaining medical/dental treatment, payment for such services and other health care operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

Any person, firm, or entity that release matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further understand that I have the right to review FAMILY DENTAL CARE's privacy notice and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire. Termination of this consent must be in writing.

____

Printed name of patient

____

Signature of Patient/Parent/Guardian and Date

Family Dental Care
COSMETIC & FAMILY DENTISTRY
16000 Stuebner Airline # 230 · Spring, TX 77379
Ph: 281.376.9068 · Fax: 281.251.4350

Broken Appointment Policy
Reservation Fee of Treatment Policy

Due to the increasing number of missed and/or cancelled appointments at our office, it is necessary to enforce a Broken Appointment Policy effective January 1, 2016.

Every effort is made to contact patients before their appointment to confirm either by phone, email or text message. Please understand that this is a courtesy reminder only. DO NOT DEPEND ON THIS. If we are unable to reach you, your appointment card will serve as your confirmation of the appointment date and time and implies your obligation to be present.

We require that you notify us of any cancellation at least 24 hours prior to your office appointment so that we may give your allocated time to another patient in need of dental care. If you arrive more than fifteen (15) minutes late for your appointment, you may have to wait or may be asked to reschedule for the next available time.

The first incident of a missed and/or cancelled appointment without 24 hours notification will be documented and the broken appointment fee will be waived. If, however, a second appointment is missed without 24 hours notification a $25 fee will be applied to your account. If 3 broken appointments occur, our office reserves the right to review and we will decide if any subsequent appointments will be made or placed on a walk-in basis. The fee must be paid before the appointment is scheduled.

An appointment is considered to be broken if any of the following occur:

- The patient fails to appear for the appointment,
- The patient cancels or reschedules with less than 24 hours notice, or
- The patient appears more than fifteen (15) minutes late for scheduled appointments.

Reservation Fee for treatment

A $50 reservation fee may be collected for treatment, at the time of the appointment is being scheduled. This applies to treatment one hour or longer. This fee will be credited towards your treatment unless you fail to show up.

I, ____ have read and understood the above mentioned policy.

____ __________________________________
Signature of Patient/Parent/Guardian Date

Family Dental Care
COSMETIC & FAMILY DENTISTRY
16000 Stuebner Airline # 230 · Spring, TX 77379
Ph: 281.376.9068 · Fax: 281.251.4350

General Consent

I, ______________________________, consent to be a patient at the above named office and agree to a radiographic and clinical examinations. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), Fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

______________________________ ______________________________

Patient/Parent/Guardian Signature Date

______________________________ ______________________________

Witness Date

Family Dental Care
COSMETIC & FAMILY DENTISTRY
16000 Stuebner Airline # 230 · Spring, TX 77379
Ph: 281.376.9068 · Fax: 281.251.4350

FINANCIAL ARRANGEMENTS FOR FAMILY DENTAL CARE

Payment for services is expected at the time service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. ***If an extended payment plan is desired, please ask us about our 6 month interest free payment plans.*** MasterCard and VISA credit card payments are also welcome.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added.

______________________________ ______________________________

Print Name (Responsible Party) **Signature and Date (Responsible Party)**

If you have dental insurance...

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have questions about "UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and ***the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.*** I/we hereby assign directly to Family Dental Care, dental insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to the claims. I/we understand I/we are financially responsible for charges not paid by this assignment.

______________________________ ______________________________

Print Name (Responsible Party) **Signature and Date (Responsible Party)**