Family Dentistry of Texoma

PATIENT REGISTRATION

First Name_____ Last Name: _____Middle Initial ___

Patient Is: __Policy Holder (check one) __Responsible Party Preferred name_____

PATIENT INFORMATION

Address: _____City: _____

State/Zip: _____ Home Phone: _____

Cell Phone: _____Work Phone: _____Ext: _____

Sex __Male __ Female Marital Status: __Married ___Single __Divorced __Separated __Widowed

Birth Date: _____Age: _____Soc Sec: _____Drivers Lic.: _____

E-Mail: _____ ___I would like to receive correspondences via e-mail

Emergency Contact _____ Emergency Contact #_____

Employment Status: __Full time __Part Time __Retired Student Status: __Full Time __Part Time

Pref. Dentist: _____ Pref. Hygienist _____

Responsible Party (if different than patient) __Responsible party is also a Policy Holder for Patient

First Name: _____ Last Name _____Middle Initial: ____

Birth Date: _____Soc Sec: _____Drivers Lic: _____

Address: _____ City, State, Zip: _____

Cell Phone: _____Home Phone: _____

Work phone: _____Ext: _____

PRIMARY INSURANCE INFORMATION:

Insurance company: _____ Insured's Employer: _____

Name of Insured: _____ Relations to Insured: __Self __Spouse __Child __Other

Insured's Address: _____ Insured's Phone: _____

Insured Soc. Sec: _____ Insured Birth Date: _____

Time 3:57 PM | Family Dentistry Of Texoma | Date 7/20/2017

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
Do you use controlled substances?	Yes No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Patient Questionnaire

1. What pharmacy do you use? _____Location_____
2. Is it okay if we send you text messages? Yes or no (circle one)
3. E-mail to communicate with you? E-mail Yes or No email (circle one)

_____

3. Name of other patients you would like to schedule at the same time (children, spouse, etc. _____

4. Whom may we thank for referring you to our practice?

____Yellow Pages ____Internet ____Newspaper
____School ____Work ____Insurance
____Sign ____Patient ____Other

Please provide us with the name, office or source referring you to us:

_____

_____

Family Dentistry of Texoma * 4506 Kemp Blvd. * Wichita Falls, Tx. 76308
Phone: 940-723-0435 * Fax: 940-766-4241 Email: frontdesk@fdtexoma.com
Dr. Steven Finley Dr. Matt Pitts

Family Dentistry of Texoma

WHAT IS YOUR IMMEDICATE CONCERN:

_____

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Personal History

1. Are you fearful of dental treatment? Scale of 1 to 10 (very)_____ YES NO
2. Have you had an unfavorable dental experience? YES NO
3. Have you ever had complications from past dental treatment? YES NO
4. Have you ever had trouble getting numb or reaction to local anesthetic? YES NO
5. Did you ever have braces, orthodontic treatment, or had your bite adjusted? YES NO
6. Have you had any teeth removed? YES NO

Smile Characteristics

7. Is there anything about your appearance of your teeth that you would like to change? YES NO
8. Have you ever whitened (bleached) your teeth? YES NO
9. Are you self-conscious about your teeth? YES NO
10. Have you been disappointed with the appearance of previous dental work? YES NO

Bite and Jaw Joint

11. Do you/would you have any problems chewing gum? YES NO
12. DO YOU/WOULD YOU HAVE ANY PROBLEMS CHEWING BAGELS OR OTHER HARD FOODS? YES NO
    YES NO
13. HAVE YOUR TEETH CHANGED IN THE LAST 5 YEARS, BECOME SHORTER, THINNER, OR WORN?
    YES NO
14. Are your teeth crowding or developing spaces? YES NO
15. Do you have more than one bite or do you clench to make your teeth fit together? YES NO
16. Do you have problems with sleep or wake up with an awareness of your teeth? YES NO
17. Do you have any problems with your jaw joint? (pain, limited opening, locking popping) YES NO
18. Do you have more tension headaches or sore teeth? YES NO
19. Do you wear or have you ever worn a bite appliance? YES NO

Tooth Structure

20. Have you had any cavities within the past 3 years? YES NO
21. Do you have dry mouth? YES NO
22. Are any teeth sensitive to hot, cold, biting or sweets? YES NO
23. Have you ever had a toothache, cracked filing, broken, chipped or cracked tooth? YES NO
24. Do you avoid brushing any part of your mouth? YES NO

Gums and Bones

25. Have you ever been diagnosed or treated for periodontal (gum) disease? YES NO
26. Have you ever experience gum recession? YES NO
27. Is there anyone with a history of periodontal disease in your family? YES NO
28. Do your gums bleed when brushing, flossing or eating? YES NO
29. Are your teeth becoming loose? YES NO
30. Have you ever noticed an unpleasant taste or odor in your mouth? YES NO
31. Have you experienced a burning sensation in your mouth? YES NO

Patient's Signature _____ Date_____

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Office Policies

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our Office Policies.

1. VERIFYING INSURANCE: As a courtesy to you, we will verify your insurance for eligibility benefits prior to your new patient appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, are your financial responsibility.

2. PAYMENT: Payment is due **at time of service**. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.

3. INSURANCE INFORMATION: New Insurance as well as **changes in INSURANCE must be** provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being **your** responsibility.

4. CHANGES IN PERSONAL INFORMATION: Changes in your address or telephone numbers should be kept with our office.

5. REQUEST FOR ADDITIONAL INFORMATION: These must be responded to immediately. Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being **your** responsibility.

6. PAYMENT PLANS: Our office offers Third Party Financing if needed to assist you in paying for any necessary treatment.

7. BALANCES: If your account balance exceeds 60 days, you will receive notice informing you that your account is **overdue.** If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collection agency. If this happens, a **collection fee** (currently 39% of the balance) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus.

8. RETURNED CHECKS: There will be a **$30** fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card. Once a check has been returned, this office will no longer accept personal checks for this payment.

9. DELINQUENT ACCOUNT: I authorize **Family Dentistry of Texoma** to contact me via current and any future cellular phone number(s), email address, or wireless device(s) regarding my delinquent account(s) I owe to **Family Dentistry of Texoma**. I authorize and its agents, representatives, and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account which is past due.

10. CANCELLATIONS / FAILED APPOINTMENTS: We request 48-hours notice if you are cancelling an appointment. There will be a $50 fee for cancellations made without 48 hours notice and for failed appointments ("no shows"). The $50 will be posted to your account, and you will not be allowed to make any other appointments for yourself or your family until it is paid in full.

Patient or Guardian Signature: _____

Date: _____

Patient Name (Please Print) _____

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I, _____, have received, have the opportunity to read, or read a copy of this office's Notice of Privacy Practice.

Print Name

Signature_____

Date_____

FOR OFFICE USE ONLY

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

____Individual refused to sign

____Communication barriers prohibited obtaining the acknowledgement

____Other (please specify)

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