

# Appt Date & Time

## Patient Information Form

Today's Date \_\_\_\_\_

Patient's Name First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Nickname \_\_\_\_\_

Address Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Primary \_\_\_\_\_ Mobile \_\_\_\_\_ Work \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Drivers License # \_\_\_\_\_ State \_\_\_\_\_

Patient Employed By \_\_\_\_\_ Phone \_\_\_\_\_

Address Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  Male  Female Marital Status  Married  Single  Divorced  Separated  Widowed

In case of emergencies, who should be notified? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Primary Phone \_\_\_\_\_

Is patient a minor  Yes  No Full Time Student  Yes  No Name of School \_\_\_\_\_

Name of Responsible Party First \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Patient  Spouse  Parent  Other: \_\_\_\_\_

If Patient is a Minor, primary residence:  Both parents  Mom  Dad  Shared Custody  Guardian  Other: \_\_\_\_\_

Address (if different from patient) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Primary \_\_\_\_\_ Mobile \_\_\_\_\_ Work \_\_\_\_\_

Employer (if different from above) \_\_\_\_\_ Phone \_\_\_\_\_

Address Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Dental Insurance Information

Primary Dental Plan Name \_\_\_\_\_ Phone \_\_\_\_\_

Address Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ ID # \_\_\_\_\_

Policy Number \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Secondary Dental Plan Name \_\_\_\_\_ Phone \_\_\_\_\_

Address Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ ID # \_\_\_\_\_

Policy Number \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

## How did you hear about us?

One of our valued patients (name of patient) \_\_\_\_\_

Facebook  Our Website

Phonebook  Internet Search

Our Location  Other: \_\_\_\_\_





If Yes, Please Explain: \_\_\_\_\_  
 Have You Had Braces? Yes No  
 If Yes, Please List Orthodontist's Name and Number: \_\_\_\_\_

Are You Aware of Having an Allergic Reaction to Any Medication or Substance? Yes No  
 If Yes, Please Explain: \_\_\_\_\_

Do You Smoke or Drink? Yes No  
 If Yes, Please Explain: \_\_\_\_\_

Are You Taking/Using any Recreational Drugs? Yes No  
 If Yes, Please Explain: \_\_\_\_\_

Have You Been Admitted to the Hospital or Needed Emergency Care During The Past Two Years?  
 Yes No  
 If Yes, Please Explain: \_\_\_\_\_

Are You Taking Birth Control Pills? Yes No  
 If Yes, Please Provide Name: \_\_\_\_\_

Are you Pregnant, or Trying to Become Pregnant? Yes No  
 If Yes, How Many Weeks? \_\_\_\_\_

When is Your Due Date? \_\_\_\_\_

Are you Nursing? Yes No  
 Are You now Under The Care of a Physician? Yes No  
 If Yes, Please Explain: \_\_\_\_\_

Are You Taking Any Medications? Yes No  
 If Yes, Please List Name And Dose: \_\_\_\_\_

**PLEASE LIST ANY MEDICATION YOU MAY BE CURRENTLY TAKING**

MEDICATION	DOSAGE	HOW OFTEN	ROUTE (ORAL/INJECTION)	WHAT IS MEDICATION TAKEN FOR?




**MEDICAL HISTORY CONTINUED**  
**HAVE YOU EVER EXPERIENCED OR HAD ANY OF THE FOLLOWING?**  
**PLEASE MARK YES OR NO TO EACH ITEM.**

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A B C or D	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives/Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insomnia/Frequent Waking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bell's Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthetic Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ringling of Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crohn's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congested Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness or Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Down Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of the Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tingling in Arms/Fingers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No



Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss/Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you have or have you had any disease, condition or problem not listed? Yes No

If Yes, Please Explain: \_\_\_\_\_

**Do any of the Following Dental Concerns Apply to you?**

Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on Lips or Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Sensation on Tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or Popping Jaw and or swollen/tender	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clenching or Grinding of Your Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Collecting/Packing Between Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lip or Cheek Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loose or Broken Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loose or Broken Fillings/Crowns	<input type="checkbox"/> Yes <input type="checkbox"/> No
Missing Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sensitivity to Pressure or Other: (cold, heat, sweets)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stained/Darker Than Normal Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spaces/Gaps Between Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tooth Ache(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Dental Concerns (Please List):	<input type="checkbox"/> Yes <input type="checkbox"/> No

I have answered all the questions to the best of my knowledge. Should further information be needed, I grant permission to ask my respective healthcare providers or agencies, who may release information to you. I will notify the dentist of any changes in my health or medication.

\_\_\_\_\_  
Patient's (or legal guardian's) signature

\_\_\_\_\_  
Date



## **Privacy Policy/HIPAA Consent**

***This notice describes how Medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.***

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call our office at 682-343-9373.

### *Information We Collect About You*

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities, you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment, we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

### *How Your Information Is Used*

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian, and can be revoked at any time with a written request. Inspired Smiles Family Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state, or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment.

### *Safeguarding Your Personal and Health Information*

We are required by law to (1) make sure medical information that identifies you is kept private, (2) provide you with our privacy policy, and (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Inspired Smiles Family Dental maintains physical, electronic, and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Inspired Smiles Family Dental.

### *Changes to Our Privacy Policy*

All new patients will review a copy of our privacy policy. Inspired Smiles Family Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

### *Your Right to Restrict Use of Information*

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed, it will remain in effect until you request a change.

**Patient Acknowledgement -** I, \_\_\_\_\_ have reviewed the privacy policy and HIPAA consent form.

**If minor, please print patient's name:** \_\_\_\_\_

**Patient or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Inspired Smiles Family Dental Worry-Free Guarantee- Terms & Conditions of Our Dental Warranty

At Inspired Smiles Family Dental, we stand behind the dental services we provide to our patients. When you visit our office, you can expect to receive nothing short of the best. Exceptional care is our passion and our mission.

We take your satisfaction and long-term health very seriously. We realize that when you commit to dental treatment, you are making a financial and personal investment in your health. We are so confident in our quality of work that we promise to help you protect that investment by honoring our work with a warranty. We do this to provide the peace of mind that every patient deserves. We will repair, replace, or provide a refund for the restorative dental treatment rendered under the following guidelines and exclusions listed below. We will replace the restorative dental work at no additional cost for materials and/or labor if there is a failure in the fabrication and if all limitations below are met.

### **Treatment eligible for warranty (ALL warranties begin on impression or initial treatment date):**

- **Veneer, Crown & bridge- 2-year warranty with custom night guard (6 months without):** Any fracture within normal use, we will replace or repair at no additional charge. Recurrent decay, wear from excessive grinding/clenching, fracture from biting into metal/hard objects, chewing ice, etc. will void this warranty.
- **Composite Filling or bonding- 2-year warranty (Excludes cosmetic bonding):** Any fracture within normal use, we will replace or repair at no additional charge. Re-current decay, wear from excessive grinding/clenching, fracture from biting into metal/hard objects, chewing ice, etc. will void this warranty.
- **Teeth whitening (In-office treatment only) - Immediate warranty:** If our teeth whitening services are unsatisfactory immediately following whitening services, we will re-treat at no additional charge. (Re-treatment must be performed within 30 days of initial treatment)
- **Partial dentures, complete dentures (permanent only, does not apply to immediate or surgical dentures or flippers) - 1-year warranty:** Any fracture within normal use, we will replace or repair at no additional charge. Re-current decay on supporting teeth (partial denture), wear from excessive grinding/clenching, fracture from biting into metal/hard objects, chewing ice, etc. We will not rebuild, repair, reline or replace the denture, free-of-charge, due to loss, neglect, abuse, break from accidental dropping/crushing, discoloration, etc. Defects or damages resulting from any service adjustments or alterations of your denture by someone other than our authorized delegate are excluded from coverage under our warranty agreement and will render it null and void.
- **Night guards - 6 month warranty:** Covered for adjustments and/or replacement for 6 months from date of impression from ill fit, cracks, or material failure. No warranty if damaged due to loss, neglect, abuse, break from accidental dropping/crushing, discoloration, etc.

**Additionally, failure to fulfill the following requirements will void the dental treatment warranty on the above services:**

**\*\*\*You must maintain a schedule of regular recall appointments at our office, to include a minimum of an oral exam every 12 months, a cleaning every 3-6 months (as recommended by Dr. Oh), bitewing x-rays every 12 months and comprehensive x-rays every 3-5 years. Refusal or non-compliance will void our warranty.**

You must maintain a high standard of home dental care on all remaining natural teeth with a minimum of brushing and flossing two times per day.

The warranty is null and void if the failure of the restorative work is due to abuse or negligence due to any form of mistreatment, accident, etc. This includes but is not limited to, biting into metal objects, chewing ice, self-adjustments, excessive grinding/clenching, etc.

The warranty is null and void if the restorative work needs to be removed or is damaged due to a dental problem or repair with the supporting tooth/teeth including but not limited to root canals, recurrent decay, gum disease, etc.

The warranty does not include any cost associated with routine maintenance required over the course of its working life. I.E. Normal relining/rebase of denture or partial denture due to natural changes in the mouth.

If the doctor determines a night guard/ occlusal guard is necessary to maintain and protect your restorative work, the warranty will be null and void if you do not have one fabricated or if you do not wear it nightly.

While waiting for the permanent restoration to be fabricated (crowns, bridges, veneers), the patient must maintain the temporary placed by the office at all times. If the temporary fractures or comes off, the office must be notified immediately. Patients are expected to be seen by the next business day to have the temporary repaired, remade or, re-cemented.

Permanent restorations typically take 1-3 weeks to be fabricated (crowns, bridges, veneers, night guards, etc.). If the patient does not return to the office within 6 weeks of initial treatment appointment to have the permanent restoration seated/delivered, the warranty will be null and void. Additionally, if the restoration/appliance must be re-made, the patient will be charged for the additional appointments and lab costs.

This warranty does not include anything not mentioned above, including but not limited to gum line desensitization, root canal therapy, retainers, Invisalign, etc.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

# Dental Practice Financial Policy

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The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.

**Financial Disclaimer** As consistent with applicable laws and the terms of your dental insurance or other dental plan coverage:

- Payment for services rendered will be due at the time of service.
- The insurance portion of the treatment plan is an estimate and not a guarantee of coverage.
- Your estimated portion will be due at the time of service.
- If your insurance carrier pays less than the anticipated amount, you will be responsible for the unpaid balance.
- I understand that I may be responsible for any unpaid balance for the procedures that are performed.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

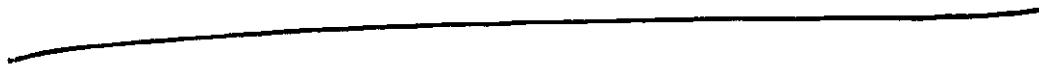
Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

I understand the above information and agree with its contents, and this will serve as my electronic signature.

Signature

X





## General Consent

You have the right to accept or reject dental treatment recommended by your dentist. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatments or the option of no treatment. It is very important that you provide your dentist with an accurate medical history before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form. Do not sign this form or agree to treatment until you have read, understood and accepted each item carefully. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.

During your course of treatment the following care may be provided to you:

- **EXAMINATIONS AND X-RAYS** Radiographs are required to complete your examination, diagnosis and treatment plan. A periodic examination will be provided by the dentist at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health. The dentist will read and diagnosis any x-rays taken. In the state of Texas a dental hygienist cannot diagnosis a patient.
- **DENTAL PROPHYLAXIS (CLEANING)** A routine dental prophylaxis involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature the office should be contacted.
- **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)** Symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment when the mouth is held in the open position. However, symptoms of TMD associated with dental treatment are usually temporary in nature and well tolerated by most patients. If need for treatment should arise, you will be referred to a specialist, the cost of which is your responsibility.



- ALLERGIES/MEDICATION I have informed the dentist of any known allergies I may have. I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).
- CONSENT I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure

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Patient's Name

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Patient's (or Legal Guardian's) Signature

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Date