DAZZLE DENTAL CARE

PATIENT INFORMATION (Confidential)

Name____ Email (Please Print)________________________________
First Middle Last

Birthdate______________Social Security #: ______________________________________ Gender: Male Female

Address:_______________________________________City________________________State_______ Zip_______________

Phone: Home #_______________________ Cell # _____________________ Work # ________________ EXT: _________

Check Appropriate Box: ___Minor ___ Single ___Married __Divorced ___Widowed Separated

If College Student, __ Full Time __Part Time School Name______________________City __________________State_____

Patient's or Parent Employer_________________Business Address_______________________City_______________State____

Spouse or Parent's Name______________________Employer__________________________Work Phone_________________

DENTAL INSURANCE INFORMATION

Name of Insured _____________________________ Relationship to Patient_______________________ Birth Date __________

SS#_____________________ Home Phone___________________ Employer Name:____________________________________

Insurance Co._________________ Tel. #________________ Ins Group#_________________ Policy ID#__________________

Do you have any secondary insurance ____ Yes ____NO: If yes, please provide information below

Name of Insured _____________________________ Relationship to Patient_______________________ Birth Date __________

SS#_____________________ Home Phone___________________ Employer Name:____________________________________

Insurance Co._________________ Tel. #________________ Ins Group#_________________ Policy ID#__________________

RESPONSIBLE PARTY (if other than yourself)

Person Responsible for this account_______________________________Relationship to the patient_____________________

Address______________________________________City____________________________State________________________

Phone # ____________________Birthdate_____________SS#______________Driver's License #______________________

Employer____________________Work Phone___________________Is this person currently seen at our office __Yes ___NO

X____Date________________
Signature of Patient or Parent if Minor

PATIENT DENTAL HISTORY

Reason for your visit____

Are you in pain? ☐ No ☐ Yes How long?____________ Describe problem:_______________________________

Date of last dental Visit: ___________________ What was done?__________________________________

Date of last dental cleaning ________________ Date of last complete series of dental X-rays_____________________

Have you ever been treated for periodontal disease or have had a deep clean before (when)______________________

What type of tooth bristle do you use? ☐Soft ☐Medium ☐Hard Times a day you brush?____ Times a week you floss?______

Previous dentist name/ location____

I am changing dentist because: check all that apply

___Recently moved into this area from __________________

___ DR/Staff personality / communication problem

___ Inadequate care

___ Fee concern

___ I'm fleeing managed care / I don't want a "list" dentist

___ To find a dentist team who understand my needs

___ Other ________________________________

I have avoided dental care in the past because:

___**Fear of** ________________________________

___Time commitment

___No perceived need

___ Financial Commitment

___Other________________________________

Emergency Contact: Name ________________________ Relationship ________________Phone Number _________________

Pharmacy Name & Intersection____

Circle all that you are concerned about/ currently have

Toothache/pain	**TMJ**	**Want to save teeth**
Cavities	Snoring/apnea	Missing teeth
Broken chipped tooth	Clinking jaw	Spacing
Broken filling	Headache	Recession
Dark teeth	Grinding/clenching	Loose teeth
Bad breath	Popping of jaw	Ugly teeth

Crooked Teeth	**Want gentle dentist**
Bleeding gums	Want whiter teeth
Pain to bite	Cosmetic dentistry
Gum disease	Fear of dentist
Sensitive to: Hot Cold Sweet Food	Poor Dentistry

LET US GET TO KNOW YOU

Where did you used to live or originally from? _____________________ Your occupation/Job___________________________

School Attended_________________________Name of Spouse & Occupation________________________________

Children's Name and Ages _________________________________ Hobbies/Interests ____________________________

Have you visited our website (Dazzledentalcare.com) yet? _____Would you like to receive our practice newsletter via email ?____

Circle how you first heard about us? Check any that apply

___Drive by (saw sign on the road)

___ Circle (Google.com, yelp, yahoo, social media)

___ Ad-pages Magazine

___I got your brochure in the mail

___ Insurance Directory

___I dreamed I should come here

___Family member already comes here (who)____________________________

___Refer by a friend (who)____

___Dazzledentalcare.com Website

___TV infomercial at the Flower Mound Community Activity Center

___ Medicaid/ TX Chip directory

___ I got your Medicaid letter in mail to bring my child in for a check-up

___ It has been more than 3 years since my last visit at Dazzle Dental

PATIENT MEDICAL HISTORY Name________________________Age_________Date___________

Are you under a physician's care now? ___Yes ___No If yes, Please explain_____________________________
Have you ever been hospitalized or had a major operation? ___Yes ___No If yes, Please explain_____________________________
Have you ever had a serious head or neck injury? ___Yes ___No If yes, Please explain_____________________________
Are you taking any medications, pills, drugs? ___Yes ___No If yes, Please explain_____________________________
Do you take, or have you taken, Phen-Fen or Redux? ___Yes ___No ____
Have you ever taken Fosamax, Boniva, Actonel or any Other medication containing bisphosphonates? ___Yes ___No ____
Are you on a special diet? ___Yes ___No
Do you use tobacco? ___Yes ___No
Do you use controlled substances? ___Yes ___No

Women: Are you :
Pregnant/trying to get pregnant ___Yes ___No Taking oral Contraceptives ___Yes ___No Nursing ___Yes ___NO

Are you allergic to any of the following?

___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Sulfa Drugs ___Local Anesthetic

Do you have or have you had any of the following? Please check all that apply

AIDS / HIV positive		Cortisone medicine		Hemophilia		Radiation treatment	
Anaphylaxis		Diabetes		Hepatitis B or C		Recent weight loss	
Anemia		Drug addiction		Hepatitis A		Renal dialysis	
Angina		Easily winded		High blood pressure		Rheumatic fever	
Arthritis/gout		Emphysema		High cholesterol		Rheumatism	
Artificial heart valve		Epilepsy or seizures		Hives or rash		Scarlet fever	
Artificial joint		Excessive bleeding		Hypoglycemia		Shingles	
Asthma		Excessive thirst		Irregular heartbeat		Sickle cell disease	
Blood disease		Fainting spells/ dizziness		Kidney problems		Sinus trouble	
Blood transfusion		Frequent cough		Leukemia		Spina bilfida	
Breathing problems		Frequent diarrhea		Liver disease		Stomach/ intestinal disease	
Bruise easily		Frequent headache		Low blood pressure		Stroke	
Cancer		Genital herpes		Lung disease		Swelling of limbs	
Chemotherapy		Glaucoma		Mitral valve prolapse		Thyroid disease	
Chest pains		Hay fever		Osteoporosis		Tonsillitis	
Cold sores/ fever blisters		Heart mummery		Pain in jaw joints		Tuberculosis	
Congenital heart disorder		Heart pacemaker		Parathyroid disease		Tumors or growths	
Convulsion		Heart trouble/disease		Psychiatric care		Ulcers	
Alzheimer's disease		Heart attack		Herpes		Venereal disease	
						Yellow Jaundice	

Comments

Signature ______________________________ Date _______________________

OFFICE ORIENTATION

Welcome! We are pleased that you have chosen our office for your dental needs. We invite you to discuss with us any questions regarding our policies. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Financial Policy

1. PAYMENT IN FULL IS DUE WHEN SERVICES ARE RENDERED.
2. IF YOU SELECT TO BE ORALLY SEDATED OR YOUR APPOINTMNET IS TWO HOURS OR LONGER, A DEPOSIT OF $100 IS REQUIRE AT THE TIME OF BOOKING OF YOUR APPOINTMENT. (If you cancel, reschedule, or miss appointment without giving us a 24 hours notice, we will apply a cancellation fee, and you will lose your deposit. ($50 per hour or 2 hours = $100.)
3. PAYMENT MAY BE MADE BY CASH, CHECK, CREDIT CARD OR THIRD PARTY FINANCING (WAC).

Appointments

Appointment Preference: Morning _________ Afternoon _________

_______ (Initial) **Appointment Confirmation:** Our office will contact you to remind you about your appointment 3-4 days ahead of your scheduled appointment. Please confirm your appointment by contacting our office or email us at **info@dazzledentalcare.com** 48 hours in advance. ***Any unconfirmed appointments may be given to other patient who is in urgent need of treatment who may wish to fill in at that time.***

_______(Initial) **Late Arrivals:** In the event you are running late, we kindly ask you call our office. Please keep in mind, a late appointment is subject to a limited visit or you will have the option to reschedule. **We respect your time** and ask that you do the same with ours.

________(Initial) **Cancellation Fee:** Your appointment is important to us. When you schedule the appointment, we reserve the Doctor's time and Assistant's time and make preparation for your arrival. Therefore, we charge a $50 cancellation fee if you cancel, reschedule, or miss your appointment without giving us 24 hours notice. If a history of short notice cancellations or "no shows" has been established, you may be ask to transfer to another office.

________(Initial) Appointments will be confirmed via phone, text, or email.

______________________________ ______________________________

Patient Name (Print) Date Signed

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Patient/Parent/Guardian Signature

______________________________ ______________________________

Financial Coordinator Signature Date

FINANCIAL INFORATION

Regarding X-rays

Dental x-rays are an important part of a dental examination, and is required in order for the Doctor to provide a thorough examination. It is our responsibility to provide a comprehensive evaluation to you. However, insurance companies limit the types and the frequency that some x-rays are taken. By limiting the allowance of x-rays the Doctor cannot present a complete evaluation to you. In the event that the Doctor requires x-rays that are not cover, you will be responsible for the fees associated with the service. If there are x-rays recommended to you that are declined, we ask that you sign a release of liability form stating that you fully understand that there are conditions that cannot be diagnosed without them.

Dazzle Dental Billing Process

As a courtesy, we will gladly file dental claims for you. Once you provide your dental insurance, we call your insurance company to verify your benefits. The information we receive from your insurance company are only an **estimation of coverage** and not a guarantee. **Your insurance policy is a contract between you and the insurance company**; therefore we cannot guarantee payment of any claims or accept the responsibility of negotiating with your insurance companies or other persons. We are not responsible for providing you with limitations, exclusions, and provisions determined by your insurance company. Your **estimated** co-pay and deductible are due and payable at the time of service.

If any insurance company does not cover or pays only a portion of the bill or rejects your claim, you will receive a statement and **the balance is your financial responsibility for services rendered**. Conversely, if your insurance company pays above the projected estimation, you will receive a credit in that amount which may be drawn as a refund upon request or applied to further treatment. If your insurance company has not paid on your claim with 60 days, the full balance will automatically be transferred to you and will be due upon billing.

Authorization

I understand and guarantee all the information on the new patient registration forms was completed correctly to the best of my knowledge and understand it is my responsibility to inform the doctor of any changes in my health and medication. I authorize the doctor and staff to perform any necessary services include taking x-rays, study models, photographs or any other diagnostic aids deemed needed by the doctor to make a thorough diagnosis. I have read and understand the billing process at Dazzle Dental Care. I also assign all insurance benefits to Dazzle Dental Care.

______________________________ ________________________

Patient's Name (print) Date Signed

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Patient's /Parent/Guardian Signature

Health Insurance Portability & Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. As required by HIPAA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information only to each of the following purposes: treatment, payment and healthcare operations.

By providing my signature below states that I have been inform of the notice of privacy practice as requested by the Health Insurance portability & Accountability Act of 1996(HIPAA) and that I may access a PDF copy of the HIPAA law document at WWW.dazzledentalcare.com or I may request a copy with the Dazzle Dental Care front staff.

☐ I do NOT authorize any information to be discussed with any family members or friends.
☐ I authorize information about treatment or appointments to be discussed with the following person (s):

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__________________________________ ________________________

Patient/Parent/Guardian Signature **Date**