BALCONES DENTAL

PATIENT INFORMATION

Date: _____

Patient Name: _____

Preferred Name: _____

SS#: _____ **Marital Status:** _____

Address: _____

City: _____

State: _____ **Zip:** _____

Email: _____

DOB: _____ **Sex:** ☐ **M** ☐ **F**

Employer: _____

Who referred you?: _____

Spouse's Name: _____

Spouse's Phone#: (_____)_____

DOB: _____ **SS#:** _____

Spouse's Employer: _____

DENTAL INSURANCE

Who is responsible for this account?:

_____

Relationship to patient: _____

Insurance Co.: _____

Subscriber ID: _____

Group #: _____

Subscriber Name: _____

Subscriber DOB: _____ **SS#:** _____

Relationship to patient: _____

Assignment and Release

I certify that I, and/or my dependent(s) have the insurance coverage listed above and assign directly to Balcones Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____

Signature of Patient, Parent or Guardian

_____ _____

Date **Relationship to Patient**

Phone Numbers

Home: (____) _____ **Work:** (____) _____ **EXT:** _____ **Cell:** (____) _____

Spouse's Cell: (____) _____ **Best time and place to reach you:** _____

Who to contact in case of emergency: _____ **Phone:** (____) _____

DENTAL HISTORY (If other than Balcones Dental)

Reason for today's visit: _____ **Former Dentist:** _____

Date of Last dental visit: _____ **Date of last dental x-rays:** _____

Please mark yes or no:

Bad Breath	☐ Yes ☐ No	**Dry Mouth**	☐ Yes ☐ No	**Lip/Cheek Biting**	☐ Yes ☐ No
Bleeding Gums	☐ Yes ☐ No	**Fingernail Biting**	☐ Yes ☐ No	**Loose Teeth**	☐ Yes ☐ No
Mouth Blisters	☐ Yes ☐ No	**Packing Food**	☐ Yes ☐ No	**Broken Fillings**	☐ Yes ☐ No
Smoker	☐ Yes ☐ No	**Grinding Teeth**	☐ Yes ☐ No	**Mouth Breathing**	☐ Yes ☐ No
Popping Jaw	☐ Yes ☐ No	**Swollen/Tender Gums**	☐ Yes ☐ No	**Mouth Pain**	☐ Yes ☐ No
Orthodontics	☐ Yes ☐ No	**Ear Pain**	☐ Yes ☐ No		

Sensitivity to: **Cold** ☐ Yes ☐ No **Heat** ☐ Yes ☐ No **Sweets** ☐ Yes ☐ No **Biting** ☐ Yes ☐ No

Your current physical health is:
Good Fair Poor

Are you taking blood thinners? Yes No

If yes, what brand _____

Are you pregnant? Yes No Week# _____

Are you nursing? Yes No

Do you require antibiotics before dental treatment?
Yes No

Are you currently in pain?
Yes No

Do you smoke or use tobacco in any form?
Yes No

How many times a week do you brush? _____

How many times a week do you floss? _____

Are you taking or have you ever taken Bisphosphonates, Fosamax, Actonel or Boniva?
Yes No

Are you currently or recently taking illegal or illicit drugs?
Yes No

Please list if you are taking any prescription/over the counter or supplement drugs? _____

_____

_____

Have you ever had any of the following diseases or medical problems? (Circle accordingly)

Y N Acid Reflux
Y N Alzheimer's disease /Dementia
Y N Anemia /Radiation Treatment
Y N Artificial Bones /Joints/ Valves
Date of surgery _____
Y N Arthritis /Gout
Y N Asthma
Y N Bacterial Endocarditis
Y N Blood Transfusion
Y N Cancer /Chemotherapy
Date of treatment _____
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing /Lung Problems
Y N Drug /Alcohol Abuse
Y N Epilepsy / Seizures / Fainting Spells
Y N Fever Blisters
Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Heart Surgery / Pacemaker / Stents
Y N Hearing Difficulties / Cochlear Implants
Y N Hemophilia / Abnormal Bleeding
Y N Hepatitis A B C
Y N High Cholesterol
Y N High Low Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason _____
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Osteoporosis
Y N Psychiatric Problems
Y N Rheumatic Fever / Scarlet Fever
Y N Severe / Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Thyroid Disease or Problems
Y N TMJ soreness/discomfort (jaw joint)
Y N Tuberculosis (TB)
Y N Venereal Disease

Are there any other problems you would like us to know? _____

_____

Are you allergic to any of the following? Or **NONE** (Please circle):

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry / Metals
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs / materials that you are allergic to: Or **NONE** (Please circle):

_____

_____

YOUR COMFORT IS IMPORTANT TO US

It is estimated that up to 80 percent of the population is afraid to see the dentist. If you feel nervous, scared or apprehensive please ask about the following sedation options, we are happy to ease your concerns.

Nitrous Oxide (Laughing Gas)-FREE

Valium Premedication-FREE

Oral Conscious Sedation-Nominal Fee

*****

OUR RIGHT TO REFUSE SERVICE

We strive to treat our patients with respect, care and concern. We ask that our team members be treated kindly in return. This policy will help to ensure a long and healthy relationship. Thank you!

Date:_____

Patient Signature:_____

BALCONES DENTAL PATIENT FINANCIAL EXPECTATION POLICY

We reserve the right to charge a fee for short notice cancellations and/or missed appointments.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care. The following is a statement of Financial Policy in order to reduce confusion and misunderstanding between our patients and practice, which we require you to read and sign prior to any treatment. If you have any questions regarding these policies, please discuss them with our Practice Manager prior to treatment.

Unless arrangements have been made in advance of either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, Master Card, American Express and Care Credit.

Your treatment plan will be based upon quality of care and not what your insurance company will or will not cover. Our office is "in-network" with many different dental insurance carriers. It is your responsibility to verify with your carrier that we are considered "in-network" with your particular insurance plan. If we are out of your network but you are on a PPO plan, we will estimate your coinsurance as a courtesy only but are not responsible for determinations made by your carrier. The estimate we give you will be based upon the limited information we are given by your insurance carrier. If it is discovered after the fact that you did not have current, correct insurance at the time services are rendered or if a claim is denied for any reason, you will be responsible for the entire balance due. In the event that your insurance plan determines a service to be "not covered" or is downgraded, you will be responsible for the entire balance due. If you disagree with your insurance company's determination, you must contact your insurance company directly.

*I FURTHER UNDERSTAND THAT I AM EXPECTED TO KEEP A DEBIT/CREDIT CARD ON FILE IN THE EVENT I DEFAULT ON THIS FINANCIAL POLICY AND AUTHORIZE BALCONES DENTAL TO CHARGE ME AFTER 90 DAYS FROM DATE OF DEFAULT.

NAME ON CARD:_____

CARD NUMBER:_____

EXPIRATION DATE:_____ CVV:_____

SIGNATURE (PATIENT OR GUARDIAN): _____

DATE: _____

Short Notice Cancellation Policy

Balcones Dental reserves the right to charge a fee for short notice cancellations and/or missed appointments. We require 48 business hours in advanced to cancel appointments.

Date:_____

Patient Signature:_____

Notice of Privacy Practices

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about out privacy practiced, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and providing performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

To Insurance Companies: On your behalf, we may disclose health information including, but not limited to, insurance claims, x-rays, digital photos, chart notations, etc... via e-mail or via postal carrier.

To Other Healthcare Providers: On your behalf, we may disclose health information including, but not limited to, personal information, x-rays, digital photos, chart notations, etc... via e-mail or via postal carrier.

Persons Involved in Care: We may use or disclose information to notify, or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures, in the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Market Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert to a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information to Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you $0 for each page, $25.00 per hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Questions and Complaints: If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S Department of Health and Human Services. **Contact the Office Manager for more information.**

The name of those whom we may discuss your care: _____

Print your name: _____

Signature: _____ **Date:** _____

Informed Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternate treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you're acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complicated or less optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

- Pain, swelling, and discomfort after treatments
- Infection in need of medication, follow-up procedures, or other treatment
- Temporary, or on rare occasion, permanent numbness, pain, tingling, or altered sensation of the lip, face, chin, gums, and/or tongue, along with possible loss of taste
- Dental parts or material swallowed and/or aspirated during treatment that would require follow-up care at an emergency center and/or hospital.
- Damage to adjacent teeth, restorations, or gums with possible bruising
- Possible deterioration of your condition which may result in tooth loss
- The need for replacement of restorations, implants, or other appliances in the future
- An altered bite in need of adjustment
- Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist
- A root tip, bone fragment, or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop
- Jaw fracture
- If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need of further treatments
- Allergic reaction to anesthetic or medication
- Need for follow-up treatment, including bone or gum surgery or root tip surgery

It is very important that you provide your dentist with accurate information before, during or 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 appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise you dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist. By signing this document I understand recommended treatment may change during the course of care. Should this occur, I grant my treating dentist permission to make any necessary changes he/she deems professionally required for my best dental health.

If you are a woman on oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

PATIENT SIGNATURE: _____ Date: _____

PARENT/LEGAL GUARDIAN: _____ Date: _____