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PREVENTIVE, COSMETIC, AND FAMILY DENTISTRY
1414 Green Oak Terrace Court Ste. 300
Kingwood, Texas 77339 • (281) 358-2711

Today's Date _____

Birth Date _____

Name _____ Age_____ Sex _____ Marital Status _____

Parent or Guardian, If Patient is a Minor _____ Patient Phone No. _____

Home Address _____ City _____ State _____ Zip Code _____

Social Security No. _____ Drivers License No. _____ Email _____

Patient's Employer _____ Occupation _____ Work Phone No. _____

Employer's Address _____
Street City State Zip Code

You are financially responsible for all dental services rendered. Dental insurance companies will not verify specific coverages. As a courtesy, we try to approximate what they will possibly pay toward your treatment. For many of our services, we have you initially pay a portion of the total fee. This amount is based on your estimated insurance coverage. You are still ultimately responsible for all fees incurred for services rendered.

Dental insurance plans rarely cover entire treatment costs. Your benefits are determined by factors such as:

a. Your cost for the policy
b. Your eligibilty
c. A deductible clause
d. A table of allowances
e. A dollar limit on covered services
f. Or any combination of the above

Most dental insurance plans are designed to help minimize dental expenses, not cover them completely. For most people the cost of a dental policy that would cover needed services 100% would cost more than the treatment itself.

Occasionally, a dental insurance company will attempt to delay payments by requesting unnecessary records, stating that they have not received a claim or requested records or stating claim is under review by a claim examiner.

If such a problem arises, we may ask you to contact your insurance carrier or your personnel department for help. As always, we will be as cooperative as possible with your insurance carrier. Many times insurance carriers will handle a claim promptly because of the persistence of the individual patient who is paying the premiums.

We are able to wait a maximum of 6 weeks for payment by your insurance carrier. After six weeks from the date services are rendered you will need to make payment in full, then be reimbursed when your insurance carrier pays. We wait six weeks for insurance payment as a courtesy to our insured patients.

I have read and understand the office policy stated above: _____
Signature of Patient or Parent

PLEASE COMPLETE THE INSURANCE INFORMATION BELOW IF APPLICABLE.

Employer of Insured _____ Corporate Phone No. _____

Employer's Address _____
Street City State Zip Code

Insurance Carrier _____ Insurance Co. Phone _____

Insurance Carrier Address _____
Street City State Zip Code

Insurance Group # _____ Employee's Social Security # _____

Employee's Name _____ Employee's Birthdate _____

Spouse's Social Security # _____

Spouse's Birthdate _____

Are Children Covered Under This Policy? _____ Names _____

PLEASE COMPLETE YOUR MEDICAL HISTORY ON REVERSE SIDE.

Smile, it's what we do!

We thank you for choosing our office for your dental needs.

Please Complete Your Medical History Below:

Are you having any dental problems now? ❒ Yes ❒ No If so, what? _____

Name of former dentist _____ Date of last dental examination _____

When did you last consult a physician? _____ Reason _____

Have you been a patient in a hospital in the past 5 years? ❒ Yes ❒ No Reason _____

Have you ever had any serious illnesses or operations? ❒ Yes ❒ No If so, what? _____

Do you have or have you had, any of the following (Please check and describe fully under remarks)

	yes	no
1. Heart Disease	❒	❒
2. High / Low Blood Pressure	❒	❒
3. Blood Disorder - Anemia	❒	❒
4. Rheumatic Fever	❒	❒
5. Heart Murmur	❒	❒
6. Mitral Valve Prolapse	❒	❒
7. Thyroid Disease	❒	❒
8. Hyperthyroidism	❒	❒
9. Diabetes	❒	❒
10. Stroke	❒	❒
11. Hives or Allergic Reaction	❒	❒

	yes	no
12. Sinus Trouble	❒	❒
13. Fainting	❒	❒
14. Arthritis	❒	❒
15. Epilepsy	❒	❒
16. Ulcers	❒	❒
17. Tested HIV Positive?	❒	❒
18. Venereal Disease	❒	❒
19. Liver or Kidney Disease	❒	❒
20. Hepatitis, Jaundice	❒	❒
21. Radiation Treatment	❒	❒
22. Have taken Bisphosphonates	❒	❒

	yes	no
23. Allergies To:	❒	❒
a. Penicilin, other Antibotics	❒	❒
b. Codeine, Aspirin	❒	❒
c. Local Anesthetic, Novocain	❒	❒
d. Latex, Metals	❒	❒
e. Other _____	❒	❒
24. Asthma	❒	❒
25. Tuberculosis	❒	❒
26. Emphysema	❒	❒
27. Excessive Bleeding	❒	❒
28. Do you Smoke / Chew Tobacco?	❒	❒
29. Are You Pregnant?	❒	❒

Do you wish to talk to the doctor privately about anything? _____ ❒ ❒

Are you taking any medicines, drugs or pills? If so, what? _____ ❒ ❒

Have you experienced any unfavorable reaction to previous dental treatment? If so, what? _____ ❒ ❒

Do you have any disease, condition or problem not listed above that you think we should know about? _____ ❒ ❒

I VERIFY THAT ALL INFORMATION COMPLETED IS TRUE AND I GIVE MY CONSENT FOR TREATMENT:

_____ _____

Signature of patient, or parent if patient is a minor. ***Referred By***

FOR OFFICE USE

NAME _____ DATE: _____

MEDICAL ALERT