Whitesboro dental
Experience the difference

545 HWY 377 North, Suite #103, Whitesboro, TX 76273
903-564-4600

# Welcome to Whitesboro Dental

Name:_____
Last First MI Title

Preferred Name:_____ ☐ Male ☐ Female

Mailing Address:_____City_____State_____ZIP_____

Physical Address (if different from above): _____City_____State_____Zip_____

SSN:_____DOB:_____

Home Phone:_____Work Phone:_____

Cell Phone: _____ E-mail Address:_____

Employer:_____Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office? _____

Have we treated your family members or friends? ☐ Yes ☐ No

If yes, please list a name(s):_____

Do you prefer to be contacted for appointment confirmation via email or phone (Text ☐ Yes ☐ No)? (Please circle preference)

## ■ Insurance – Primary ■

Subscriber Name: _____Relationship to Patient:_____Subscriber DOB:_____

Subscriber SSN/ID:_____Subscriber Employer:_____

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone:_____Group Number:_____

## ■ Insurance – Secondary ■

Subscriber Name: _____Relationship to Patient:_____Subscriber DOB:_____

Subscriber SSN/ID:_____Subscriber Employer:_____

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone:_____Group Number:_____

## ■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Whitesboro 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

**Responsible Party Signature**_____

**Relationship**_____ **Date**_____

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**Print Your Name**_____**Date of Birth**_____

## Medical History

Do you have a personal physician? ☐ Yes ☐ No
Physician's Name:_____
Physician's Phone:_____
Date of last visit:_____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? Yes No
If yes, please explain:_____
Do you use tobacco in any form? ☐ Yes ☐ No
Have you had any metal rods, pins, or implants placed? ☐ Yes ☐No
Are you taking any medications? ☐ Yes ☐ No
Please list each one:_____

_____

Have you ever had any surgical procedures? ☐ Yes ☐ No
Please list each one: _____

| Yes | No | Conditions | Yes | No | Conditions | Yes | No | Conditions |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Abnormal Bleeding | ☐ | ☐ | Fever Blisters | ☐ | ☐ | Sickle Cell Disease |
| ☐ | ☐ | ADHD/ADD | ☐ | ☐ | Glaucoma | ☐ | ☐ | Sinus Problems |
| ☐ | ☐ | Alcohol Abuse | ☐ | ☐ | HIV+AIDS | ☐ | ☐ | Stroke |
| ☐ | ☐ | Anemia | ☐ | ☐ | Heart Attack | ☐ | ☐ | Thyroid Problems (hypothyroidism or hyperthyroidism) |
| ☐ | ☐ | Angina Pectoris (Chest Pain) | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Tuberculosis |
| | | | ☐ | ☐ | Heart Surgery | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Anxiety | ☐ | ☐ | Hemophilia | ☐ | ☐ | Others: _____ |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Hepatitis A | | | |
| ☐ | ☐ | Artificial Heart Valve | ☐ | ☐ | Hepatitis B | | | |
| ☐ | ☐ | Asthma | ☐ | ☐ | Hepatitis C | | | |
| ☐ | ☐ | Blood Transfusion | ☐ | ☐ | High Blood Pressure | | | |
| ☐ | ☐ | Cancer | ☐ | ☐ | Joint Replacement | | | |
| ☐ | ☐ | Chemotherapy | ☐ | ☐ | Kidney Problems | | | |
| ☐ | ☐ | Colitis | ☐ | ☐ | Liver Disease | | | |
| ☐ | ☐ | Congenital Heart Defect | ☐ | ☐ | Low Blood Pressure | | | |
| | | | ☐ | ☐ | Mitral Valve Prolapse | | | |
| ☐ | ☐ | Depression | ☐ | ☐ | Migraines | | | |
| ☐ | ☐ | Diabetes (Type I or II) | ☐ | ☐ | Pacemaker | | | |
| ☐ | ☐ | Difficulty Breathing | ☐ | ☐ | Radiation Therapy | | | |
| ☐ | ☐ | Drug Abuse | ☐ | ☐ | Rheumatic Fever | | | |
| ☐ | ☐ | Emphysema | ☐ | ☐ | Seasonal Allergies | | | |
| ☐ | ☐ | Epilepsy | ☐ | ☐ | Seizures | | | |
| ☐ | ☐ | Facial Surgery | ☐ | ☐ | Sexually Transmitted Disease | | | |
| ☐ | ☐ | Fainting Spells | ☐ | ☐ | Shingles | | | |

| Yes | No | Allergies |
|---|---|---|
| ☐ | ☐ | Codeine |
| ☐ | ☐ | Dental Anesthetics |
| ☐ | ☐ | Jewelry |
| ☐ | ☐ | Latex |
| ☐ | ☐ | Metals |
| ☐ | ☐ | Penicillin |
| ☐ | ☐ | Others: _____ |

| Yes | No | If female, please answer. |
|---|---|---|
| ☐ | ☐ | Are you taking Birth Control Pills? |
| ☐ | ☐ | Are you pregnant? If so, # of weeks_____ |
| ☐ | ☐ | Are you nursing? |

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

**Signature** _____**Date** _____

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**Name**_____**Date of Birth**_____

## Dental History

How may we help you today? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before any dental treatments? ☐ Yes ☐ No

If yes, please provide reasons. _____

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a periodontal (gum) treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomforts in your jaw joint? (TMJ) ☐ Yes ☐ No

Are you under stress? (new job, moving, relationship) ☐ Yes ☐ No

Do you clench or grind your teeth at daytime and/or nighttime? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed during brushing or flossing your teeth? ☐ Yes ☐ No

How many times a day do you brush? _____/day for how long? ____sec/min

How many times a day or a week do you floss? _____/day or _____/week

Are your teeth sensitive in general? ☐ Yes ☐ No

If yes, please check ones that your teeth are sensitive to. ☐ Hot ☐ Cold ☐Sweet☐ Pressure ☐ Others:_____

Have you lost any teeth? ☐ Yes ☐ No

Have you ever had any serious/difficult problems with any previous dental work? ☐ Yes ☐ No

If yes, please explain._____

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

If yes, please explain._____

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

_____

Here at Whitesboro Dental, we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

| | | |
|---|---|---|
| Teeth Whitening | Exam and Cleaning | Tooth Colored Fillings |
| Braces | Crown and Bridge | Implant |
| Sealants | Nitrous Oxide | Night Guard/Sport Guard/Anti-Snore Guards |

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## Returned Check Policy

If a check is returned from your bank for whatever reasons such as insufficient funds, stop payment, etc., there will be a charge of $25.00 non-refundable service charge for each returned check. Upon notification, you must replace the returned check amount with a certified check, money order, cash, or credit card payment within 14 business days.

## No call no show and Same Day Cancellation Policy

We do understand your emergencies related to your family, work, and sickness. However, please do understand that when we make your appointment, we reserve time exclusively for you. Therefore, we do enforce $50.00 NO CALL NO SHOW FEE and $50.00 SAME DAY Cancellation fee. To avoid being charged, please give us a notice by 2 business days before your appointment date. You can give us a notice by calling our office 903-564-4600 or by sending us a text. For example, if your appointment is on Wednesday, please let us know by Monday of that week. If your appointment is on Monday, please let us know by Thursday of the week before.

## Appointment Confirmation Policy

We ask you to return our phone call or to reply to our text message by replying 'yes' to confirm or 'reschedule' to reschedule your appointments. If you need to reschedule or cancel, we ask you to please let us know by 2 business days before your appointment date. All unconfirmed appointments will be replaced by another patient requesting that time.

Our text line phone number is for text ONLY. Our text phone number is different from our office phone number, and you will receive the text phone number when we send you the appointment reminder text to your cellular phone. Please do not call our text phone, as we do not check voicemail. To leave a voicemail, please call our office at 903-564-4600.

I confirm that I have read and understood the above information.

**Patient Signature _____Date _____**

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# Financial Policy

Our office wants all our patients to be able to comfortably afford dental care. We will gladly discuss our payment options with you before beginning your treatment. We proudly offer the following financial policies so that our patients can have the opportunity to decide a payment option that would suite your needs the best.

**Dental insurance** - Our office will gladly work with you to help you get the maximum insurance benefit available to you. We do accept PPO insurance, However, we do not accept HMO, Medicaid, or Medicare plans, except some Medicare Plans that carry a small dental PPO plan. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be asked to pay your deductible if applicable and your co-payments for the charges on the day the service is rendered. We are happy to file the forms necessary to assure you receive the full benefit of your dental insurance. We will gladly estimate your coverage, however, many variables could exist from many insurance carriers, such as deductibles, annual maximum, and your insurance's allowable fee limitations, non-coverage procedures, and other restrictions. **Therefore, we cannot guarantee any of the estimated charges. Your insurance is an agreement between you and the insurance company, which, if you work for a company, it is set by your human resource department from your work.** If your insurance has not paid its portion within 60 days from the start of your treatment, it is you that are responsible to pay for any unpaid balance. If your insurance gets terminated or expired, it is you that responsible to pay for any unpaid balance.

**Payment Options**

1. **Cash, check, or credit card (excluding Care Credit) –** As a courtesy, to anyone less than age 60 years old with no dental insurance, we offer a 5% discount. However, if you are a new patient or a patient who has not been to our office for a while, we do not accept a personal check on their first visit.
2. **Care Credit** - for treatment **over $300,** you can apply in our office, and the approval is known within minutes. We offer **3, 6, or 12 month interest free plans financed through Care Credit,** There is no down payment required, no annual fees, and no payment penalty for this plan. Regarding the interest, if the agreed payment is not met in the allowed time, the interest will be 22.98%, and accrue from the first day. **You do not get a cash discount when you pay with Care Credit as Care Credit charges us interest.**
3. **Senior** – As a courtesy, to anyone 60 years old and over with no dental insurance, we offer a 10% discount. However, if you are a new patient or a patient who has not been to our office for a while, we do not accept a personal check on their first visit.

**Patient Signature** _____**Date** _____

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# HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information, and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that,

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ Yes ☐ No
May we leave a message on your answering machine at home or on your cell phone? ☐ Yes ☐ No
May we discuss your medical and dental conditions with any member of your family? ☐ Yes ☐ No
If YES, please list 1) name(s), 2) relationship with you, and 3) their best phone numbers to reach

_____

_____

This consent was signed by _____
(Print Your Name)
Signature _____ Date _____

Witness _____ Date _____

For Office Use Only
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because of the following reason(s).
___Individual refused to sign.
___Communication barriers prohibited obtaining the acknowledgment.
___An emergency situation prevented us from obtaining acknowledgment.
___Other (Please specify)_____