

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 _____

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
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	HIV+AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Arrhythmia (irregular heart beat)			
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris (Chest Pain)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems (hypothyroidism or hyperthyroidism)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Others _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B			Yes No Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Type I or II)	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Others: _____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Migraines			
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker			
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	Yes	No	If female, please answer.
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking Birth Control Pills?
<input type="checkbox"/>	<input type="checkbox"/>	Facial Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? If so, # of weeks _____
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease			

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** _____

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

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** _____

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

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** _____

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

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) _____