DENTAL HISTORY

Please check the following:	Yes	No
-Sensitivity (hot, cold, sweet) - Tooth pain or discomfort when chewing?	☐	☐
-Headaches, earaches, neck aches or jaw joint pain	☐	☐
-Mouth ulcers or cold sores	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath or bad taste in your mouth	☐	☐
-Snoring	☐	☐
Do you have or have you had any of the following?	☐	☐
-Dentures / Partial dentures	☐	☐
- Implants	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐
-C-PAP	☐	☐

	YES	NO
If you could whiten your teeth for a cost anyone could afford, would you, do it?	☐	☐
Do you smoke, use chewing tobacco or vape? How much? For how long?	☐	☐
If I could change my smile, I would:		
-Make my teeth brighter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Replace black metal fillings with natural tooth-colored fillings	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that do not match	☐	☐
-Have a smile makeover	☐	☐

Please share the following dates:

-Your last cleaning

-Your last oral cancer screening

-Your last complete X-Rays

Name of Previous Dentist :

Phone Number:

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

-Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

MEDICAL HISTORY UPDATE

Please check the following:

Y N	Y N	Y N	Y N
☐ ☐ Allergies (Seasonal)	☐ ☐ Emphysema	☐ ☐ Osteoporosis	☐ ☐ Ulcers
☐ ☐ Anemia	☐ ☐ Fainting	☐ ☐ Jaundice	☐ ☐ Have you ever taken Fosamax
☐ ☐ Arthritis	☐ ☐ Glaucoma	☐ ☐ Jaw Joint Pain	☐ ☐ Other:
☐ ☐ Artificial Joints	☐ ☐ Head Injuries	☐ ☐ Pacemaker	
☐ ☐ Artificial Heart Valve	☐ ☐ Heart Disease	☐ ☐ Pre-Medication	
☐ ☐ Asthma	☐ ☐ Heart Conditions	☐ ☐ Radiation (head/neck)	
☐ ☐ Back Problems	☐ ☐ Heart Murmur	☐ ☐ Respiratory Problems	**For WOMEN Only**
☐ ☐ Cancer	☐ ☐ other Heart conditions	☐ ☐ Seizures	☐ ☐ Birth Control Pills
☐ ☐ Chemotherapy	☐ ☐ Hepatitis A B C	☐ ☐ Stomach Problems	☐ ☐ Breast-feeding
☐ ☐ Circulatory Problems	☐ ☐ High Blood Pressure	☐ ☐ Stroke	☐ ☐ Pregnant
☐ ☐ Diabetes	☐ ☐ Low Blood Pressure	☐ ☐ Swelling – Feet/Ankles	**1-3 mos 3-6 mos 6-9 mos**
☐ ☐ Dizziness	☐ ☐ Kidney Disease	☐ ☐ Thyroid Disease	
☐ ☐ Excessive Bleeding	☐ ☐ Liver Disease	☐ ☐ Tuberculosis	

Do you have any of the following drug allergies?

☐ ☐ Aspirin	☐ ☐ Penicillin
☐ ☐ Codeine	☐ ☐ Sulfa
☐ ☐ Erythromycin	☐ ☐ Tetracycline
☐ ☐ Ibuprofen	☐ ☐ Tylenol
☐ ☐ Latex	☐ ☐ Other

Are you under a physician's care? What for?

Are you taking any medications? What? Why?

Is there any other medical or dental information we should know about?

Patient (Parent of Child) Signature:_____ **Date**_____ **Doctor Signature:**_____ **Date**_____

OralID™
Shine Light. Save Lives.

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID™ examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection.

Our office charges $35 per screening with the OralID. We will attempt to bill your insurance, but you will be responsible for any unpaid amount or denial by your insurance company.

☐ Yes, I request that your staff perform an examination with the OralID. I accept financial responsibility for this examination.

_____ _____ _____

Signature Name Date

☐ No, I prefer to not have this examination at this visit.

_____ _____ _____

Signature Name Date

the LEWISVILLE DENTIST

PATIENT REGISTRATION

Patient's Name		**Birth date**	**Age** **Sex: M F O**
Home Address	**City**	**State**	**Zip**

YOUR cell phone #	***YOUR E-mail address*** **Your Soc Sec #**
Work Phone #	
Home Phone #	**YOUR Driver's License Number** **(is not necessary if you are paying at the time of service)**

Your Place of Employment: **Your Occupation**

Please Circle One: Single Married Child Other

If patient is minor, we will need:

Mother's Name & Birth date

Father's Name & Birth date

Person responsible for this account:

Name of significant other/spouse (or parent if minor):

EMERGENCY INFORMATION

Name, Address, & Telephone of A relative not living with you:

Family Physician: *Phone Number:*

Preferred Pharmacy: *Phone Number:*

How did you hear about our office?

DENTAL INSURANCE INFORMATION (Primary Carrier)		**If you have a dual insurance coverage, complete this for the second coverage (We are HAPPY TO HELP)**
Insured's name		
DOB **SS#**		Insured's name DOB SS#
Insured's employer		Insured's employer
Insurance Co		Insurance Co
Insurance Co Address		Insurance Co Address
Phone #		Phone #
Group # **Policy #**		Group # Local #

the LEWISVILLE DENTIST

Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Signature of Patient/Guardian Print Name Date

the LEWISVILLE DENTIST

Informed Consent For Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information may be used to:

- Conduct, plan, direct my treatment, and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. My signature will also serve as a release should I request treatment or radiographs be sent to other attending Doctors in the future.
- Obtain payment from third-party payers in your behalf, ie... dental insurance.
- Conduct normal healthcare operations such as quality assessments and required local/federal certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, financial or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize The Lewisville Dentist and its employees to contact me with information regarding my dental appointments, treatment, billing, health, and services.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Please list any other parties who can have access to your dental information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have been informed & consent to these notices & release information to the above person(s)

_____

Patient Name

_____

Patient/Guardian Signature Date