PLANO DENTAL EXCELLENCE
masterpiece smiles • pampered care

Patient Information

First Name: _____ MI: _____ Last Name: _____

Gender: _____ DOB: _____ Age: _____ DL#: _____ SS#: _____

Email: _____

Street Address: _____ City: _____ Zip: _____

Home #: _____ Cell Phone #: _____ Work Phone #:_____

Emergency Contact: _____ Emergency Contact Phone #: _____

Responsible Party

Name of person responsible for this account: _____ Relation to Patient: _____

Street Address: _____ City: _____ Zip: _____

Phone #: _____ DL#: _____ SS#: _____

Employer: _____ Is this person a patient in our office? : _____

Insurance Information

Name of Insured: _____ Relation to Patient: _____

Birthdate: _____ SS/ID #: _____Contact Phone # : _____

Name of Employer: _____ Office Phone #: _____

Insurance Company: _____ Group #:_____ Policy #_____

Address: _____ City_____ Zip: _____

Secondary Insurance

Name of Insured: _____ Relation to Patient: _____

Birthdate: _____ SS/ID #: _____Contact Phone # : _____

Name of Employer: _____ Office Phone #: _____

Insurance Company: _____ Group #:_____ Policy #_____

Address: _____ City_____ Zip: _____

Payment Policy

Payment for today's visit, and future visits, are due at the time of service or upon agreed amounts with prior financial arrangements. If applicable, insurance claims are filed by Plano Dental Excellence, and I am responsible for paying my estimated portion at the time of service. I understand not all services are covered by insurance and will pay the outstanding amount. All emergency dental services performed without prior financial arrangements must be paid in full at the time of rendered services.

I have read the above conditions of treatment and payment and agree to their content.

Name: _____Signature: _____ Date: _____

Medical History

To our patients: As your dental office, our primary concern is your overall health. Health problems you may have or medications you are taking can play an important role in the care you will be receiving.

Overall health: □ Good □ Fair □ Poor

Please check any of the following conditions which you have had or presently have:

□ AIDS or HIV	□ Emphysema	□ Low blood pressure
□ Arthritis or joint disease	□ Eye disease/glaucoma	□ Mental health problem
□ Artificial joints	□ Eating Disorder	□ Malignant hyperthermia
□ Asthma	□ Gallbladder trouble	□ Low blood sugar
□ Blood disorder	□ Habit forming/illegal drugs	□ Tuberculosis
□ Blood transfusion	□ Hay fever	□ Difficulty breathing
□ Bronchitis	□ Heart attack muscle spasms	□ Thyroid trouble
□ Back Problems	□ Heart murmur	□ Diabetes
□ Cancer, tumor or growth	□ Heart surgery	□ Cardiac pacemaker
□ Muscular dystrophy	□ Stomach ulcers	□ Hemophilia
□ Chemotherapy	□ High blood pressure	□ Pacemaker
□ Chest pain	□ Immunological disorder	□ Radiation therapy
□ Cold Sores/Fever Blisters	□ Irregular heart beat	□ Sexually transmitted disease
□ Convulsions, epilepsy	□ Hepatitis or liver disease	□ Stroke
□ Damaged heart valves/MVP	□ Kidney trouble; dialysis	□ Other: _____

I have read all the above conditions and unless otherwise marked, I am stating I do not have, nor ever had any of these conditions. Initials: _____

	YES	NO
Have there been any changes to your general health in the past year?	□	□
If so, describe._____		
Are you under the care of a physician? Date of last visit: _____	□	□
If so, for what are you being treated? _____		
Name of Physician: _____ Phone #: _____		
Do you have any known allergies? If so, what? _____	□	□
Have you had any illness, operation or been hospitalized in the past 2 years?	□	□
If so, describe. _____		
Do you use smoke/ use tobacco products?	□	□
Are you pregnant or think you may be pregnant?	□	□
Are you nursing?	□	□

Medications

Are you taking or have you ever taken any of the following:

Bisphosphonates?

(Indicated for osteoporosis or breast cancer) Boniva, Fosamax, Actonel, Zometa, Xgeva..... □ □

Anticoagulants?

(Blood thinners) Coumadin, Warfarin, Aspirin, Plavix..... □ □

Please list any medications you are currently taking:

Name of Medication	Reason for taking it	Strength & Frequency

Dental History

Reason for visit today: _____ How often do you see the dentist? _____

When was your last dental visit? _____ What was done? _____

Previous Dentist Name: _____ Phone #: _____

How often do you brush? _____ How often do you floss? _____

YES	NO	
□	□	Are your teeth sensitive to hot or cold?
□	□	Are your teeth sensitive to sweets?
□	□	Do any teeth hurt on biting or chewing?
□	□	Do you notice any mouth odor/bad taste?
□	□	Do you gums bleed or hurt?
□	□	Do any of your family members have gum disease?
□	□	Do you have any loose teeth?
□	□	Does food get caught in between your teeth?
		If yes, where? _____
□	□	Do you clench or grind your teeth?
□	□	Do you have tired jaws?
□	□	Clicking or popping in your jaws?
□	□	Difficulty opening or closing your mouth?

YES	NO	
□	□	Do you feel nervous about today's visit?
□	□	Have you ever had an upsetting dental experience?
		If yes, what? _____
□	□	Are keeping all your teeth important to you?
□	□	Have you ever had orthodontic treatment?
□	□	Have you ever had periodontal treatment?
□	□	Have you ever had a serious head/mouth injury?
□	□	Do you frequently get cold sores/ fever blisters?
□	□	Do you smoke or chew tobacco?

If you could change anything about your smile, would you:

□ Make it whiter □ Make it straighter □ Close spaces □Repair chipped teeth □Replace missing teeth

□ Replace metal fillings with tooth colored fillings □ Have a smile makeover

Cancellation Policy:

We value your time and we appreciate the time you spend with us at our office. Please be aware that we require 48 hour notice in the event that you need to reschedule your appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. Additionally, if you are more than 20 minutes late without prior notice for an appointment, it is also considered a missed appointment. A fee of ***$60.00 per hour*** will be charged to you; this fee cannot be billed to your insurance and will be your direct responsibility.

To the best of my knowledge, all of the information provided is true and correct. If I ever have any change in my health, I will inform the Doctor and/or office at the next appointment.

Name: _____Signature: _____ Date: _____

Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment.
- Obtain payment from third party payers (dental insurance)
- Conduct normal healthcare operations such as quality assessments

I have received, read, and understand your *Notice of Privacy Practices*. I understand that this organization has the right to change the *Notice of Privacy Practices* from time to time and that I may ask to obtain a current copy of it at any time.

I understand that I may revoke an authorization to disclose any personal health information at any time by written notice.

Patient Communication

In general, the HIPAA privacy rule gives you the right to request a restriction on uses and disclosure of their protected health information (PHI). You provide the right to request confidential communication or that a communication of PHI is made by different means.

Please indicate how you would like to be contacted: (check all that apply)

All appointment confirmations are typically sent through text/email unless refused below.

Cell phone: □ OK to leave a voice message with detailed information
□ OK to send detailed information via text
□ Leave a message with only a call back number

Written Communication:
□ OK to email detailed information
□ OK to mail detailed information
□ No email or mail communication permitted

Home/Work phone:
□ Permission to leave a message with detailed information
□ Leave a message with only a call back number

I authorize these persons to have access to my PHI (such as appointment time/date, treatment, account balance):
Please give full name of specified person.

Spouse/Partner: _____ Parent: _____ Child: _____

Secretary: _____ Other: _____

By signing below, I acknowledge that a copy of the Notice of Privacy Practices is available at my request and I have been given the opportunity to ask any questions regarding this notice.
I also certify that Plano Dental Excellence can communicate with me as indicated above and can correspond with those persons who I have designated regarding my treatment at this office.

Name: _____Signature: _____ Date: _____