

**Endodontics, Periodontics, Orthodontics**

6700 Colleyville Blvd, Colleyville, TX 76034

Tel. (817)722-6065 Fax. (817)549-4969

**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION**

|  |  |
| --- | --- |
| DATE | CELL PHONE CARRIER |
| LAST NAME FIRST NAME M.I. | |
| PREFERS TO BE CALLED BY | |
| ADDRESS | |
| CITY STATE ZIP | |
| HOME PHONE NO. CELL PHONE NO. | |
| BIRTHDAY |  |
|  | |
| SOCIAL SECURITY NO. | EMAIL |

IF THIS

APPOINTMENT

IS FOR YOU

START HERE

|  |  |  |
| --- | --- | --- |
| DATE | | CELL PHONE CARRIER |
| LAST NAME FIRST NAME M.I. | | |
| ADDRESS | | |
| CITY STATE ZIP | | |
| HOME PHONE NO. CELL PHONE NO. | | |
| BIRTHDAY |  | |
| SOCIAL SECURITY NO. | | EMAIL |
| IF YOUR CHILD’S NAME OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO | | |

IF THIS

APPOINTMENT

IS FOR

YOUR CHILD

START HERE

|  |
| --- |
| GETTING TO KNOW YOU |
| IS ANOTHER RELATIVE OF YOURS A PATIENT AT OUR OFFICE? |
| NAME |
| RELATIONSHIP |
| EMERGENCY CONTACT |
| PHONE NO. |

|  |
| --- |
| PRIMARY INSURANCE INFORMATION |
| INSURANCE COMPANY |
| SUBSCRIBER ID NO. |
| Group NO. |
| Employer |
| Ins Phone NO. |
| SUBSCRIBER NAME |
| DATE OF BIRTH |
| SOCIAL SECURITY NUMBER |
| RELATIONSHIP TO PATIENT |

|  |
| --- |
| SECONDARY INSURANCE INFORMATION |
| NAME OF INSURANCE COMPANY |
| SUBSCRIBER ID NO. |
| Group NO. |
| Employer |
| Ins Phone NO. |
| SUBSCRIBER NAME |
| DATE OF BIRTH |
| SOCIAL SECURITY NUMBER |
| RELATIONSHIP TO PATIENT |

|  |
| --- |
| WHO MAY WE THANK FOR YOUR REFERRAL |
| Please circle |
| FAMILY/FRIEND: |
| DR REFERRAL: |
| INSURANCE DRIVE BY AD/MARKETING INTERNET |
| SOCIAL MEDIA OTHER: |

1. I authorize Dental Specialists Center dentists to perform diagnostic procedures and treatments as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child’s) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child’s) health care, advice and treatment to another dentist.
2. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
3. Women who are pregnant should not undergo a CBCT scan/or x-rays due to potential danger to the fetus. Please inform the Doctor or staff if you are pregnant or planning to become pregnant.
4. I understand that I am responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If required, I also understand that my account may be sent to a collection agency.
5. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.
6. HIPAA RELEASE – I authorize Dental Specialists Center to give my information to the following persons:

Please check none if you do not authorize us to release any of your information at this time. 

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If it becomes necessary to reschedule an appointment, we request the courtesy of a 48 hour notice. If you cancel, do not show or miss your appointment without the requested notice, **we will assess a $100.00 non-refundable missed appointment service charge.** This fee is strictly enforced and will not be covered by your insurance.

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Responsible Party’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_

**LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  

  

  

**LIST ALL MEDICATIONS CURRENTLY BEING TAKEN (BY MEDICATION NAME)**

  

     

**MEDICAL HISTORY**

  

  

  

  

  

  

  

  

  

  

  

  

  

  

  

  

 

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I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_