Dr Black DENTAL CARE

219 Rock Prairie Rd Ste. 100▪ College Station, TX 77845▪ 979-695-8000

PATIENT INFORMATION

Date: ___________________________

Patient Information

□Mr. □Mrs. □Miss □Ms.

LEGAL NAME:

Last: ____

First ________________________________MI________

Preferred Name: ________________________________

Address _______________________________________

City_____________________State______Zip __________

Hm Phone ______________________________________

Mobile Phone ___________________________________

Emplyr_ ____________________Phone_______________

Email ______ __________________________________

Sex (Circle) M or F Driver's Lic #__________________

SSN# __________________DOB______/______/______

Marital Status (Circle) Single Mar Div. Sep Wid

Insurance Information

Primary INS _____________________________________

Policy Holder ____________________________________

ID # or SSN ________________Group #______________

Policy Holder DOB _______/________/___________

Patient's Relationship to Policy Holder (Circle)

Self Spouse Child Other

Employer: _____________________________________

Parent/ Guardian (If applicable) _________________

Address: _____________________________________

City: _____________ ___________________________

State ___________ Zip __________________

Do you have more than ONE Dental Insurance?

YES or NO

Write Information on back of this Form -------→

In Case of Emergency

Person to contact in case of emergency

Name ____

Relationship ___________________________________

Phone # _______________________________________

Alternate Phone # ______________________________

Referral Source

Who may we thank for referring you to our practice? (Circle)

Doctor Family Friend Yellow Pages

Flyer Close to Home/Work Internet

Other

Name______________________________________

How May We Contact You?

Preferred contact method	Home Phone	Mobile Phone	Mail	Email
Preferred contact method for confirmations	Home Phone	Mobile Phone	Mail	Email
Preferred contact method for recall	Home Phone	Mobile Phone	Mail	Email

The above information is true to the best of my knowledge. I authorize insurance benefits be paid directly to the physician. I understand I am financially responsible for any balance. I authorize Dr. Black Dental Dr. Black Dental Care or insurance company to release any information required to process my claims.

Patient/Guardian Signature ________________________________ Date __________________________

PATIENT HEALTH & DENTAL INFORMATION

MEDICAL HISTORY

Name: ______________________________ Date____________

Do you have any of the following: (please check)

- ______High blood pressure
- ______Anemia
- ______Arthritis
- ______Artificial Valve
- ______Blood transfusion
- ______Circulatory problems
- ______COPD
- ______Diabetes
- ______Diagnosis of ARC/HIV
- ______Epilepsy
- ______Excessive bleeding
- ______Fainting tendency
- ______Glaucoma
- ______Heart problems (heart murmur, Valve Defect or Replacement)
- ______Hepatitis A (infectious)
- ______Hepatitis B (serum)
- ______Jaundice
- ______Joint Replacement
- ______Malignancies
- ______Nursing mother currently?
- ______**Pregnant currently**? Due Date______________
- ______Respiratory problems
- ______Rheumatic fever
- ______Sinus Problems
- ______Stroke
- ______Tested positive for AIDS/HIV
- ______Thyroid disease
- ______Tuberculosis
- ______Unfavorable reaction to dental anesthetic
- ______Venereal disease

Other ____

Do you have a condition that requires antibiotic premedication before dental appointments Y or N?

Do you use any tobacco products: Y or N If YES, what type? ____

Are you allergic to any medications: Y or N If YES, please list ______________________________________

Please list other allergies: ____

Physician's Name _________________________________ Phone # __________________________________

Are you presently under the care of a physician? Y or N If YES, for what? ______________________________

Are you currently taking any medications: Y or N If YES, please list ____________________________________

____

DENTAL HISTORY

Date of your last dental treatment or cleaning: ___________ do you have panoramic x-ray or Full Mouth x-rays that are less than 5 years old? ________ Do you have Bitewing x-rays that are less than 1 year old? ________

Do you have a history of: (please check)

______Gum Disease	______Halitosis (bad breath)	______Grinding Teeth
______Abscesses	______Teeth Sensitivities	______Clicking or Popping TMJ
______Sores (ulcers)	______Cold Sores/Fever Blisters	______Pain in Jaw Joint

Are there any other dental conditions or experiences of which we should be made aware of?

CONSENT FOR SERVICES

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I grant my permission for any and all photographs, intra oral photos or x-rays to be used for educational purposes as well as my own diagnosis if necessary.

APPOINTMENT POLICY

In this very busy world, we make every effort to schedule your appointment to fit your personal schedule. We do not overbook as do so many medical and dental practices. Your appointment is yours exclusively, should you cancel your appointment with less than 48 hours notice or fail to be here at your appointed time, our dental chair is empty, time is wasted. You have delayed treatment for another patient. Overhead expenses continue and the cost of dentistry ultimately rises. We are committed to improving your oral health. You on the other hand must be committed to making your scheduled appointments in order to receive the necessary dental treatment. **We ask that you provide us with no less than 24 hours notice should you need to cancel or reschedule an appointment for any reason.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

I, ____, have received a copy of this office's Notice of Privacy Practices.

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the provisions listed below. The following provisions identify our policies governing insurance claims:

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. **Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our office from your insurance company**. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the estimated co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. **The co-payment is only an estimate of charges and may be found to be insufficient after review by your insurance company.**
- Insurance payments ordinarily are received within 30-60 days from the time of billing. **If your insurance company has not made payment to our office within 60 days, we will ask you to pay the entire balance at that time.** You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.
- Returned checks are subject to a $25.00 admin fee and all balances older than 60 days will be subject to collection action and fees.

I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

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

Patient/Guardian: ____________________________________ Date: ______________________________