Welcome To Our Office

Date _____

Patient Name _____ Birth Date _____

Address _____ City _____ Zip Code _____

Home Phone: _____ Cell Phone _____ Soc Sec # _____

Email Address: _____

EMPLOYMENT INFORMATION

Name of Employer _____ Phone # _____

DENTAL INSURANCE INFORMATION

Name of Ins. Co. _____ Insured's Employer _____

Name of Insured (if different from patient) _____ Insured's Date of Birth _____

Insured's Soc Sec # _____ Insured's Relationship to Patient _____

Group #/Group Name _____ Insured Retired? From What Company _____

SPOUSE, PARENT OR RESPONSIBLE PARTY

Name _____ Relationship to Patient _____

Address _____ City/Zip Code _____

Employer _____ Phone # _____

DENTAL HISTORY

Do you see a dentist regularly? YES NO If yes, name of Dentist _____ How Long? ____

DENTAL CONDITION (CIRCLE YES OR NO)

HAVE YOU EVER:

Been told you have gum trouble.....Yes No

Have you had trench mouth/?.....Yes No

Been treated for periodontal disease..... Yes No

Had orthodontic treatment..... Yes No

DO YOU EVER:

Do you clench your teeth?.....Yes No

Do you have swollen gums?.....Yes No

Do you have bleeding gums?.....Yes No

Do you have tooth sensitivity?..... Yes No

Are you unhappy with the appearance of your teeth or smile?..... Yes No

Would you be disturbed if you lost your teeth?..... Yes No

FOR WOMEN ONLY

Are you pregnant? ..... Yes No

Are you taking birth control pills? ..... Yes No

Are you taking hormonal supplements? Yes No

If yes, what month_____Are you nursing..... Yes No

Have you been through menopause..... Yes No

MEDICAL CONDITION (CIRCLE YES OR NO)

DO YOU HAVE OR HAVE YOU EVER HAD:

Heart Failure..... Yes No

Heart Disease..... Yes No

Heart Attack..... Yes No

Congenital Heart Defect Yes No

Heart Murmur..... Yes No

High Blood Pressure. Yes No

Low Blood Pressure.. Yes No

Heart Pacemaker.....Yes No

Arteriosclerosis..... Yes No

Mitral Valve Prolapse. Yes No

Artificial Heart Valve.. Yes No

Heart Surgery..... Yes No

Congenital Heart Disease	Yes	No	Rheumatic Fever.....	Yes	No	Rheumatic Heart Disease	Yes	No
Stroke.....	Yes	No	Blood Thinners.....	Yes	No	Angina Pectoris.....	Yes	No
Arthritis.....	Yes	No	AIDS.....	Yes	No	Blood Transfusions.....	Yes	No
Rheumatism.....	Yes	No	HIV Positive.....	Yes	No	Hemophilia.....	Yes	No
Pain in Jaw Joints (TMJ)	Yes	No	Frequent Headache.....	Yes	No	Blood Disorder Anemia...	Yes	No
Ever Taken Cortisone....	Yes	No	Cold Sores/Fever Blisters....	Yes	No	Sickle Cell Disease.....	Yes	No
Artificial Joint.....	Yes	No	Do You Smoke.....	Yes	No	Bruise Easily.....	Yes	No
Kidney Disease.....	Yes	No	History of Smoking.....	Yes	No	Drug Addiction.....	Yes	No
Liver Disease.....	Yes	No	Drink Alcohol.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Yellow Jaundice.....	Yes	No	Phen-Fen Diet Medication.	Yes	No	Ever Fainted.....	Yes	No
Thyroid Disease.....	Yes	No	Emphysema.....	Yes	No	Dizzy Spells.....	Yes	No
Diabetes.....	Yes	No	Chronic Cough.....	Yes	No	Nervousness.....	Yes	No
Ulcers.....	Yes	No	Tuberculosis.....	Yes	No	Psychiatric Treatment.....	Yes	No
Hiatal Hernia.....	Yes	No	Asthma.....	Yes	No	Osteopenia/Osteoporosis	Yes	No
Cancer.....	Yes	No	Hay Fever.....	Yes	No	Bisphosphonates Meds...	Yes	No
Radiation Therapy.....	Yes	No	Allergies or Hives.....	Yes	No	Chemotherapy.....	Yes	No
Sinus Trouble.....	Yes	No	Hepatitis A (infectious)...	Yes	No	Glaucoma.....	Yes	No
Cataracts .....Yes		No	Hepatitis B (Serum).....	Yes	No	History of Surgery.....	Yes	No
Cosmetic Surgery.....Yes		No	Hepatitis C.....	Yes	No			
Height: _____			Weight: _____					

HAVE YOU OR DO YOU:

Been under the care of a physician in the last year..... Yes No Reason: _____
Had a major illness..... Yes No Reason: _____
Take aspirin daily..... Yes No Reason: _____
Had abnormal bleeding tendencies ("Free Bleeder", Hemophilia or prolonged bleeding after extraction)..... Yes No

PLEASE LIST ANY PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING

Name _____ Reason _____ Dosage _____
Name _____ Reason _____ Dosage _____
Name _____ Reason _____ Dosage _____
Name _____ Reason _____ Dosage _____
Name _____ Reason _____ Dosage _____

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO MEDICATIONS..... Yes No
If yes, name of medication(s) _____

PHARMACY YOU USE_____ ***PHONE NUMBER*** _____

NAME OF PHYSICIAN_____ ***PHONE NUMBER***_____
DATE OF LAST PHYSICAL _____

CONSENT

The undersigned hereby authorizes the doctor or staff to take radiographs (x rays), study models, photographs, or any diagnostic aids deemed appropriate to make a thorough diagnosis. All responsibility of payment for Dental Services provided in this office for myself or my dependent is totally mine, due and payable at the time of services unless a previous financial arrangement has been made.

I certify that all the above questions were answered truthfully and to the best of my knowledge with the understanding that they were necessary to provide quality dental care in a safe and efficient manner. I will inform the doctor of any changes in my medical history and any changes in my medications.

Patients Signature_____ Date_____
(Guardian if patient is a minor)
Dentist Signature_____ Date_____

COMAL HILLS
Dental

21477 State Highway 46 West, # 101 Spring Branch, Texas 78070 ~ 830-438-2121

Financial Policy

As we enter this doctor-patient relationship, we agree to provide quality healthcare at a fair and reasonable price. You in turn, agree it is your obligation to be prepared to pay at the time of service and to understand the benefits of your insurance. We want to explain our financial policy to you so there are no unpleasant surprised.

-Co-payments, deductibles and/or coinsurance are due at the time of service. We accept Cash, Personal Check, Visa, Mastercard, Discover, American Express and Care Credit. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due at the time services are provided unless earlier arrangements have been made. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 90 days with no payment activity will be reported to the credit bureau.*

Initials _____

-Your insurance policy is a contract between you and your insurer. Do not assume your policy covers everything or pays 100%. It is your responsibility to know what your policy covers and what it does not. We cannot guarantee your benefits. Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. Any disputes about payment must be resolved between you and your insurance company. Failure to provide accurate insurance information within 3 days from the date of service will result in the balance becoming your financial responsibility. **Initials** _____

As a courtesy to you, we will file primary participating insurance for you. Please bring your insurance card with you to every visit. I Understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered.

Initials _____

A $35.00 fee will be assessed for all returned checks. A $50.00 fee will be added to your account each time a cancellation is made without providing 24 hour notice. We do understand that emergences do happen and we will take that into consideration if the need arises. **Initials** _____

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

_____

Responsible Party Printed Name

_____ _____

Responsible Party Signature Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN

ACKNOWLEDGEMENT FORM

I, _____, have reviewed Comal Hills Dental
(Patient Name)
Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
(Signature of Patient) (Date)

Comal Hills Dental was unable to obtain acknowledgement because:
Patient Refused – Reason _____
Other _____
_____

****

Due to the HIPPA regulations. I hereby authorize the following names of those listed below to discuss and participate in my medical care (names of family members/friends who may be calling on your behalf; it is not necessary to list doctors' names.) I understand that if the names are not listed below, the office of Comal Hills Dental cannot release any information.

Names	Relationship
_____	_____
_____	_____
_____	_____

_____ _____
(Signature of Patient) (Date)