Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Email address:_____

Preferred Contact Number:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:

_____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

How were you referred to our office? _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

AIDS/HIV
Artificial Heart Valve
Artificial Joints
Asthma
Bleeding Disorder
Breathing Problems
Cancer
Chemo
Chemical Dependency
Diabetes
Epilepsy
Glaucoma
Growths
Headaches
Head Injuries
Heart Problems
Hepatitis
High Blood Pressure
Inflammatory Diseases
Kidney Disease
Liver Disease
Nervous Disorders
Pacemaker
Psychiatric Care
Radiation Treatment
Reflux/GERD
Require Pre-Med
Sinus Problems
Stroke
Sexually transmitted disease
Tuberculosis
Tumors

Women: Are you pregnant:_____ trimester:_____Nursing:_____

Do you drink Alchohol?_____How often:_____

Do you use tobacco?_____Type:_____How much per day?_____

Are there any changes in medications if this is an updated form_____

Please list all medications you are currently taking, or products a medication list for our records:_____

Allergies

☐ **Pain Relievers**
- ☐ Acetimenophen/Tylenol
- ☐ Aspirin
- ☐ Codeine
- ☐ Ibuprofen/Advil

Local Anesthetics
- ☐ Articaine
- ☐ Lidocaine
- ☐ Epinephrine
- ☐ Marcain

☐ **Latex**

☐ **Other_____**
_____

Antiobiotics
- ☐ Penicillin
- ☐ Clindamycin
- ☐ Clarithromycin (Biaxin)
- ☐ Other _____

Anxiety
- ☐ Nitrous Oxide
- ☐ Valium
- ☐ Halcion

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

Do you have any special concerns about your visit? Nervous Time Cost Other_____

Do you like laughing gas and/or sedation during dental visits? Yes No

Dental History

Reason for today's visit_____

Approximate date of last dental visit_____

Have you ever had head or neck radiation?_____

Have you ever taken Fosamax, Boniva, or medicines containing bisphosphonates? Yes No

Are you happy with your teeth and their appearance? Yes No

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

Make them whiter

Have a smile makeover

Make them straighter

Replace existing dental work that doesn't match

Replace missing teeth

Is it important to you to keep your teeth?
If yes, why? _____
Have you lost any teeth:
If yes, why?_____

Have you ever had orthodontic treatment? Yes No

Do you feel you will eventually wear dentures? Yes No

Do you wear an appliance for grinding? Yes No

Have you experienced any of the following with your jaw?

Pain in or around ears

Wake up with headaches/migraines

Difficulty opening and/or closing

Popping and/or clicking in jaw

Difficulty chewing

Stiff neck muscles

Have you ever been diagnosed with a TMJ problem? Yes No

Do you have chronic dry mouth? Yes No

Does food collect between any of your teeth? Yes No

How often do you brush your teeth?_____Floss?_____

Do you gums bleed while brushing or flossing? Yes No

Have you ever been told you have periodontal disease? Yes No

Do you have any lumps, sores or growths near or in your mouth? Yes No

Are there any other dental concerns that you would like to clarify?

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____

Signature of patient, parent or guardian

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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

_____ Date: _____ Relationship to Patient:_____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient:_____
Signature of guarantor of payment/responsible

Kipton Anderson, DDS
5303 Colleyville Boulevard, Suite B – Colleyville, TX 76034 – (817) 485-2111

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communicational barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)

_____
_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address:_____

Home Phone:_____ **Alternate Phone:**_____

E-mail:_____ **SS#:** _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes, Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Dr. Kipton Anderson, DDS, PLLC
5303 Colleyville Boulevard, Suite B
Colleyville, TX 76034
817-485-2111
Fax: 817-656-5704
kipdds@gmail.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will *not* affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, _____**,** have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my ptoterct3ed health information to carry out my treatment, payment activities & health care operations.

Signature:_____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal representatives name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT: I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will *not* affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my consent.

Signature:_____ Date: _____