DENTON
-DENTAL CENTER-

Today's date _____

Patient name _____**Birth date** _____

SS#_____**Driver's license #** _____

Home Address:_____City/State_____Zip_____

Home Phone _____**Cell Phone**_____**Work phone** _____

Email_____

Name of Responsible Party-_____The" Responsible Party" is the person obligated to pay the patient's dental bill; it may or may not be the patient listed on this form. You may mark "SAME" if information is the same as you've written in the above section.

Relationship to Patient_____

Dental Insurance Company (If you have a secondary insurance, please provide that information together with your primary dental insurance so that we can give you the best estimate possible)

Company Name _____

Subscriber's Name_____Subscriber's ID # _____

Subscriber's Birthday_____ Subscriber's Social Security # _____ - _____ - _____

Who may we thank for referring you to our office?_____

Name of Previous Dentist _____Phone Number _____

Date of last Dental visit _____Date of last x-rays _____

Type of cleaning done: ☐ Scaling &Root planning (**deep cleaning**) ☐ Prophylaxis

Reason for leaving previous Dentist?

Your height _____ Your weight _____

Are you aware of any jaw pains or clenching/grinding? ☐ Yes ☐ No

Any dental complaints/concerns you would like to be addressed today, such as a toothache, broken tooth?

Are you happy about your smile? ☐ Yes ☐ No If no, what would you like to change?

Medical Doctor's Name _____Phone number_____

Pharmacy name/phone number_____Fax_____

Previous hospitalizations (please list dates and reason) _____

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Health History

Have you ever had or currently have any of the following *check all that apply*

- ☐ Allergies
- ☐ Arthritis or Rheumatism
- ☐ Infective Endocarditis
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Asthma
- ☐ Bleeding abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency/Recreational Drug Abuse
- ☐ Chest Pains
- ☐ Circulatory Problems
- ☐ Cortisone-Steroid Treatment
- ☐ Epilepsy, Convulsions or Seizures
- ☐ Headaches
- ☐ Epilepsy, Convulsions or Seizures
- ☐ Kidney or bladder Disease
- ☐ Nervous Problems
- ☐ Recent Weight Loss
- ☐ Rheumatic Fever
- ☐ Sinus Problems/Hayfever
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Ulcer
- ☐ Fainting
- ☐ Tobacco Use (smoking or dip)
- ☐ HIV/AIDS
- ☐ Family History of Diabetes, Heart Disease, or Stroke
- ☐ Chest Pains
- ☐ Artificial Heart Valves, Screws, etc.
- ☐ Cardiac Transplant
- ☐ Heart Problems
- ☐ Low Blood Pressure
- ☐ Artificial Joints
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Transfusion
- ☐ Pace Maker
- ☐ Chemotherapy
- ☐ Chronic Diarrhea
- ☐ Congenital Heart Lesions
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Infectious Disease
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Shortness of Breath
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Thyroid Trouble
- ☐ Sexually Transmitted Disease
- ☐ Sleep Apnea
- ☐ History of HPV (Human Papillomavirus)
- ☐ Tuberculosis
- ☐ Sickle Cell Disease

****Allergies:*** **Do you have any drug allergies or have you ever had an adverse reaction to any medications, anesthetic, materials, or latex?**

☐ Yes ☐ No If yes, what do you react to? _____

For Women: Are you pregnant, or do you suspect that you are pregnant? ☐ Yes ☐ No

No Due date _____Doctor's Name_____Phone number_____

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Has your doctor ever told you that you need to take antibiotic premedication prior to any dental appointment or procedure? (This is usually due to having had joint replacement, heart surgery, chemotherapy, etc.) ☐ Yes ☐ No If yes, explain.

_____

Please list all prescription and over-the-counter medications you are currently taking and the reasons you take them. *(Attach list if needed)*

_____

_____

Signature **Date**

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Official Financial Agreement

Today's visit will be paid by:

☐ **Cash** ☐ **Check** ☐ **Credit Card** ***(all major credit cards)*** ☐ ***Carecredit***

All fees for service are due at the time of the initial appointment; therefore patients are expected to pay at the time of service. All returned checks must be paid in cash within 10 days with a service charge of $35. Dental insurance can be processed with the following conditions: The office must be able to verify coverage or the entire payment for services will need to be paid at the current appointment. Secondary insurance can be filed for you, but you will be responsible for paying this as most secondary insurance is sent directly to the subscriber. Any charges not paid by the insurance remain the responsibility of the patient. A dental plan is nothing more than a contract between the employer and the insurance company to partially pay for certain services. We will file your insurance as a courtesy for our patients, with the mutual understanding that all fees unpaid by the insurance company are the immediate responsibility of the patient. If your insurance has not paid within 90 days of services rendered, you will need to make the full payment to this office and reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries.

The insured has a better ability to deal with the insurance company and the employer responsible for the policy.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.
Also, I, the undersigned, certify that I (or my dependent) have dental insurance, and assign directly to Todd Balington, DMD, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

X _____
Signature (for financial responsibility) ***Date***

I grant my permission to you or your assignee, to telephone me at home/work/email and discuss matters related to this form and you may leave a detail message. I have read the above conditions of treatment and payment and agree to their content. If I am unable to keep the appointment, I realize that a 48-hour notice is required
Without proper notification, I will agree to pay the current office visit charge of $50.00 per hour.

X _____
Signature ***Date***

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Emergency Contact Information

Please list the names and telephone numbers of two relatives (or friends) not living with you that we may contact in the case of an emergency.

Name _____Relationship _____

Phone (_____)_____

Address _____

Name _____ Relationship _____

Phone (_____)_____

Address_____

Release

I AUTHORIZE AND GIVE CONSENT TO THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES INCLUDING X-RAYS AND TREATMENT AS MAYBE NECESSARY FOR PROPER DENTAL CARE. I AM RESPONSIBLE TO INFORM THIS OFFICE OF ANY CHANGE IN HEALTH HISTORY.

X _____
Signature Date

Health Information Authorization

I AUTHORIZE THE DENTAL OFFICE TO SHARE MY PROTECTED HEALTH INFORMATION WITH THE FOLLOWING PERSONS:

Name _____Relationship _____Phone (_____)_____

Name _____Relationship _____Phone (_____)_____

Name _____Relationship _____Phone (_____)_____

Practices Documentation

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name (please print)

X _____
Signature ***Date***

☐ patient refusal to sign
☐ personal representative not available to sign
☐ language, communication, or effects of disability impeded acknowledgement
☐ emergency care impeded acknowledgement
☐ other, please specify

Written acknowledgement could not be documented due to the following reason(s):