Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental Health.

Patient Information

Name____ Soc. Sec. #__________________
Last Name First Name Initial
Address____
City______________________ State______ Zip_________ Home Phone____________________
Cell Phone____________________ Email ______________________________________
Sex M__ F__ Age________ Birthdate__________ Single ____ Married ____ Widowed____ Separated____ Divorced____
Patient Employed by ______________________________ Occupation____________________
Business Address ______________________________ Business Phone ____________________
Business Email ____
Whom may we thank for referring you? ____
Notify in case of emergency ______________________ Home Phone ____________________
Cell Phone ______________________ Business Phone ______________________________
Email ____

Primary Insurance

Person Responsible for Account ____
Last Name First Name Initial
Relation to Patient ________________ Birthdate____________ Soc. Sec. # ____________________
Address (if different from patient) ______________________ Home Phone ____________________
City ______________________ State _________ Zip ______________________
Cell Phone ______________________ Email ______________________________________
Person Responsible Employed by ______________________ Occupation ____________________
Business Address ______________________________ Business Phone ____________________
Business Email ____
Insurance Company ______________________________ Phone ____________________
Insurance Address ____
Group # ______________________ ID/ Subscriber # ______________________________
Name(s) of other dependents under this plan ____

Additional Insurance

Is patient covered by other dental insurance? Yes___ No ___
Subscriber Name ______________________ Relation to Patient ____________ Birthdate________________
Address (if different from patient) ______________________________ Soc. Sec. #____________
City ____________________ State______ Zip ____________ Home Phone ____________________
Cell Phone____________________ Email ______________________________________
Subscriber Employed by ______________________________ Business Phone ____________________
Business Email ____
Insurance Company ______________________________ Phone ____________________
Insurance Address ____
Group # ______________________ ID/ Subscriber # ______________________________
Name(s) of other dependents under this plan____

Please complete both sides.

Dental History

What would you like us to do today? ______________________________________ Are you in dental discomfort today? ________

Former Dentist ______________________________ Address ____

Dentist's email ______________________________ Phone # ____

Date of last dental care ________________________ Date of last x-rays ____

Circle ◯ Yes or No if you have had problems with any of the following:

Y N Bad Breath	Y N Food collection between teeth	Y N Periodontal treatment	Y N Sensitivity to Sweets
Y N Bleeding gums	Y N Grinding or clenching teeth	Y N Sensitivity to cold	Y N sensitivity when biting
Y N Clicking or popping jaw	Y N loose teeth of broke fillings	Y N sensitivity to hot	Y N sores of growths in mouth

How often do you brush? ____ Floss? ________________________________

How do you feel about the appearance of your teeth? ____

Have you ever experienced and adverse reaction during or in conjunction with a medical or dental procedure: Y N

Other information about your dental health or previous treatment ____

Medical History

Physician's name____Phone________________________________

Date of last visit ___________________________ Have you had any serious illnesses or operations? Y N

If yes, describe ____

Are you currently under physician care? Y N If yes, describe____

Have you ever had a blood transfusion? Y N If yes, give approximate dates ____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Circle ◯ Yes or No whether you have had any of the following:

Y N AIDS/HIV Positive	Y N Cough, persistent	Y N Jaw pain	Y N Shingles
Y N Anaphylaxis	Y N Cough up blood	Y N Kidney disease or malfunction	Y N Shortness of breath
Y N Anemia	Y N Diabetes		Y N Skin rash
Y N Arthritis, Rheumatism	Y N Epilepsy	Y N Liver disease	Y N Spina Bifida
Y N Artificial heart valves	Y N Fainting	Y N Material allergies (latex, wool, metal, chemicals)	Y N Stroke
Y N Artificial Joints	Y N Food allergies		Y N Surgical Implant
Y N Asthma	Y N Glaucoma	Y N Mitral valve prolapse	Y N Swelling of feet or ankles
Y N Atopic (allergy prone)	Y N Headaches	Y N Nervous problems	
Y N Back problems	Y N Heart murmur	Y N Pacemaker/ Heart Surgery	Y N Thyroid disease or Malfunction
Y N Blood disease	Y N Heart problems		
Y N Cancer	Describe____________	Y N Psychiatric care	Y N Tobacco habit
Y N Chemical dependency	Y N Hemophilia/ Abnormal bleeding	Y N Rapid weight gain/loss	Y N Tonsillitis
Y N Chemotherapy		Y N Radiation treatment	Y N Tuberculosis
Y N Circulatory problems	Y N Herpes	Y N Respiratory disease	Y N Ulcer/ Colitis
Y N Cortisone treatments	Y N Hepatitis	Y N Rheumatic/ Scarlet fever	Y N Venereal disease
	Y N High blood pressure		

Is patient currently taking any medications? If yes, list all:

____

____

Does patient have drug allergies? If yes, list all:

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Authorization

I have reviewed the information of this questionnaire, and is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature____ Date____

**********Payment is due in full at time of treatment, unless prior arrangements have been approved*********

Princeton Family Dental

OFFICE POLICIES

By signing below you are indicating that you have been informed and have had the opportunity to ask any questions regarding any of our policies. We value your business!

FINANCIAL POLICY

In the interest of good dental care practice, it is our desire to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good dental health and we wish to spend our time and energy toward that end. To assist our patients, we offer the following methods for taking care of their account at our office:

- **Payments are due at time of service.**
- We accept Credit Cards (Visa, MasterCard, and Discover), Cash, Check and Care Credit.
- As a courtesy, we will gladly bill your Insurance when you provide us with the current and correct information along with any necessary forms. Often times we are able to contact your insurance prior to your appointment, and ESTIMATE your portion of the bill. **We ask that you pay your estimated portion of the bill (co-pay) along with any deductible due at the time of service. You are ultimately responsible for knowing what your insurance coverage is and for payment of your account.** If your insurance does not pay on a claim after our attempts to collect, it will be the patient's responsibility to pay the balance and/or collect for the insurance co.
- For patients who qualify, we offer various payment and interest plans through Care Credit. There are numerous payment options that will fit comfortably in almost any monthly budget. This company offers a revolving line of credit that can be used by the whole family for ongoing treatment without having to reapply. Ask us for information if you are interested in this option.
- On major restorative work such as crowns, bridges, dentures or partials, you would be asked to pay the cost of the treatment at the time of service. It is your responsibility to know if you have a waiting period on your insurance policy resulting in a declined claim.

CANCELLATION POLICY

Please know that when you schedule an appointment with the doctor or the hygienist, this is a time that is specifically reserved for you. Last minute cancellations and "no shows" result in other patients often going without treatment as these appointment times are not available to offer them. Due to such late cancellations and missed appointments, we have instituted the following policy: **"All appointments must be cancelled at least 24 hours in advance. You will be charged $50 for appointments not cancelled with at least 24 hours' notice".** Insurance companies do not cover this expense. This will be the sole responsibility of the patient. Thank you and we hope we don't have to enforce this policy.

Princeton Family Dental

ESTIMATES AND FEES

After x-rays and an examination, we will gladly provide you with pre-treatment estimates of future work to be done. If you have insurance, the estimated fees on the pre-treatment are good as long as the insurance company is using that price schedule. For our Non Insured patients, the fees on the pre-treatment are guaranteed up to 30 days from the diagnosing appointment.

DELIQUENT ACCOUNTS

After reasonable time and effort between Princeton Family Dental and the responsible party to collect money owed, we may deem it necessary to turn said account to an outside source for payment. If this account is assigned to any agency, attorney/law suit, the prevailing party shall be entitled to reasonable attorney's fees and cost collection.

NOTICE OF PRIVACY PRACTICES (HIPAA)

There is an attached copy of the Notice of Privacy Practices (HIPAA) on the clipboard. This notice provides in detail the uses and disclosures of your protected health information, your individual rights, how to exercise said rights, and this practice's legal duties with respect to your information. Princeton Family Dental reserves the right to change the terms and the Notice of Privacy Practices. **By signing below, you are noting that you understand said HIPAA policies.** Upon your request, we will be happy to provide you with your own person copy of our Privacy Practices.

CONSENT OF ASSIGNMENT

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of patient's records.

I hereby assign all medical/dental/surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to:

Princeton Family Dental
710 W. Princeton Dr.
Princeton, TX 75407

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges (whether or not paid by said insurance). I hereby authorize said assignee to release all information necessary to secure payment.

Please let us know if you have any questions or concerns about our policies. Your signature is acknowledging you have read and understand said policies on both of these pages.

____________________________________ ____________

Signature of Patient or Responsible Party Date

HIPAA Acknowledgement

Please initial that you have read:

_____ 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. You have the right to revoke this consent at any time by giving this office written notice of your revocation. Please understand that we could no longer file insurance claims for you and that it will not affect any action we took in reliance on this consent prior to receiving your revocation and that we may decline to treat or continue treating you if you revoke this consent.

_____ I acknowledge a copy of this office's Notice of Privacy Practices is available to me at my request.

_____ I hereby authorize payment to this practice of the insurance benefits otherwise payable to me and recognize and accept personal responsibility of any remaining balance.

Please check the following that apply:

☐ OK to leave a message regarding appointment, insurance information, call back requests, etc. on my home phone and/or cell phone.

☐ OK to leave a message regarding appointment, insurance information, call back requests, etc. with a family member.

☐ OK to leave a message regarding appointment, insurance information, call back requests, etc. on my work phone.

Please list any and all persons we can speak to on your behalf:

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____ __________

Signature of Patient (Guardian if patient is a minor) Date