Patient Information Sheet

Rev 04/2018

Patient Name_____Preferred_____ Date of Birth _____

Address _____

Hm#_____Mobile#_____Work#_____

E-Mail Address _____

Whom may we thank for referring you?_____

Insurance Information: We cannot file insurance without the following information

Subscriber_____Relation_____ Date of Birth_____

Group #_____ Subscriber ID or Social Security #:_____

Employer_____ Insurance Carrier: _____

Ins. carrier telephone # :_____Address _____

City_____ State _____ Zip Code _____

Secondary Insurance Carrier: _____

_____

*If you could change anything about your smile, what would it be?*_____

_____

_____

Financial Agreement:

We file insurance for our patients as a courtesy and do our best to estimate your out of pocket expense as closely as possible. However, we are not familiar with all plan provisions and exclusions; that is the responsibility of the policy holder. Instances arise where insurance carriers will only share information with the subscriber; thus we ask you to contact your insurance carrier with questions prior to treatment eliminating uncertainty. All balances are due by patient regardless of what insurance carriers pay after 30 days. All balances must be resolved prior to any case deliveries. Also, please note any appointment cancellations without 24 hour notice will access a 75.00 fee.

Patient Signature _____ Date: _____

Woodlands Dental Group
ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
(ACKNOWLEDGEMENT 2018)

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE WOODLANDS DENTAL GROUP'S NOTICE OF PRIVACY PRACTICES.

_____
Patient Name (Please Print)

_____ _____
Patient Signature **Date**

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one)

□ **Parent** □ **Guardian** □ **Power of Attorney** □ **Other:**_____

PLEASE NOTE: IT IS YOUR RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT

DENTAL OFFICE USE ONLY

We attempted to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement.

___ A communication barrier prevented us from obtaining acknowledgement.

___ The individual was unwilling to sign

___ Other: _____

_____ _____
Team Member Signature **Date**

Medical History Info For: _____DOB_____Date_____

Physician Information:

Physician's Full Name_____Contact#_____

Are you currently under Physician's care? _____ If Yes, For what? _____

Are you currently taking any medication, drugs or pills? _____ if yes, please list_____

_____

_____

Have you been hospitalized in the past two years? _____ If yes, for what_____

_____

Have you taken Fosamax, Boniva, Actonel, Zometa, Skelid or Aredia? □yes □ no If yes, which_____

Women only:

Are you pregnant? □ yes □ no if yes, When is your due date? _____

Are You Nursing? □ yes □ no Are You taking Birth Control? □ yes □ no Are You on Hormone Therapy? □ yes □ no

Patient's Current or previous Conditions

Are you allergic to any Medications? □ yes □ no If yes, Please list_____

Medical Conditions: Please check all that apply

□ Heart Attack
□ Heart Murmur
□ Serious Accident
□ Artificial Heart Valve
□ Heart Surgery
□ High/Low Blood Pressure
□ Rheumatic Fever
□ Anemia
□ Blood Disease
□ Blood Transfusion
□ Stroke
□ Deep Vein Clot
□ Hemophilia
□ Headaches
□ Sickle Cell Disease
□ Glaucoma
□ Diabetes
□ Pacemaker
□ Scarlet Fever
□ Thyroid Disease

□ Parathyroid Disease
□ Kidney Disease
□ Liver Disease
□ Hepatitis A , B or C _____
□ Yellow Jaundice
□ Cancer
□ Chemotherapy
□ Ulcers
□ Gastro Intestinal Upset
□ Acid Reflux
□ Lung Disease
□ Tuberculosis
□ Shortness of Breath
□ Emphysema
□ Asthma
□ Sinus Trouble
□ Hay Fever
□ Frequent Cough
□ Rheumatism
□ Arthritis

□ Osteoporosis
□ Swelling of feet/ankles
□ Artificial joints/Replacements
□ Psychiatric care
□ Epilepsy/Seizures
□ Nervousness
□ Fainting
□ Hypoglycemia
□ HIV/AIDS
□ Cold sores/Fever Blisters
□ Chemical Dependency
□ HPV
□ Cortisone Treatment
□ STD
□ Gout
□ Other_____

_____
Patient/Guardian Signature

Reviewed BY:_____