Patient, Pharmacy and Insurance Information

Patient Information

Prefix: _____ First Name: _____ Middle Name: _____ Last Name: _____

Suffix: _____

Street: _____ Zip: _____ City: _____ State: _____ Country: _____

Preferred Phone #: _____ Is this a mobile number? Yes ☐ No ☐

Email Address: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Unspecified

Emergency Contact: _____ Emergency Phone #: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Responsible Party

First Name: _____ Middle Name: _____ Last Name: _____

Street: _____ Zip: _____ City: _____ State: _____ Country: _____

Date of Birth: _____ Sex: ☐ Female ☐ Male ☐ Unspecified

Responsible Party Signature: _____ Date: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Street: _____ Zip: _____ City: _____ State: _____

Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: Date of Birth:

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

Secondary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Ins Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: _____ Date of Birth: _____

Patient Relationship to Subscriber: ☐ Child ☐ Disabled Dependent ☐ Husband ☐ Self ☐ Wife ☐ Other Dependent

Subscriber SSN: _____

Health History

Reason for Visit: ☐ Broken Tooth ☐ Check-up ☐ Cosmetic ☐ Dentures ☐ Tooth Pain ☐ Other: _____

Height: _____ ft _____ in Weight: _____ Patient Date of Birth: _____

Are you under the care of a primary physician? ☐ Yes ☐ No

Primary Physician's Name: _____ Physician's Phone Number: _____

Date of Last Physical:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No

Are you taking or have you taken Oral Bisphosphonates (e.g., FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g., ZOMETA, AREDIA)?

☐ No ☐ Yes How Long? _____

Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No

Are you allergic or have you had an adverse reaction to any of the following?

☐ **None** ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Latex ☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline

☐ Other: _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

☐ **None**

Check any conditions that apply to you:

☐ **None**

☐ Alcoholism

☐ Allergies or Hives

☐ Anemia

☐ Arthritis

☐ Artificial Joint/Pins

Type: _____

Age: _____

☐ Aspirin Therapy

☐ Asthma

☐ Blood Thinners

☐ Blood Transfusion

☐ Breathing Problems

☐ Cancer

Type: _____

☐ Chemotherapy

☐ Coumadin Therapy

☐ Dementia

☐ Diabetes

Type: _____

☐ Dialysis

☐ Drug Addiction

☐ Epilepsy

☐ Excessive Bleeding

☐ Fainting/Dizziness

☐ Hearing Impairment

☐ Heart Murmur

☐ Heart Surgery

Date: _____

☐ Heart Trouble

Type: _____

☐ Hepatitis

Type: _____

☐ High Blood Pressure

☐ HIV

☐ Kidney Disease

☐ Liver Disease

☐ Low Blood Pressure

☐ Lung Disease/COPD

☐ Lupus

☐ Mitral Valve Prolapse

☐ Mobility Impairment

☐ NON-DENTAL Implants

Type: _____

☐ Organ Transplants

Type: _____

☐ Pace Maker

☐ Psychiatric Care

☐ Radiation Therapy

☐ Radiosurgery

☐ Rheumatic Fever

☐ Seizures

☐ Sexually Transmitted Disease

☐ Sinus Problems

☐ Stomach Problems

☐ Stroke

☐ Thyroid Disease

☐ Tuberculosis(TB)

☐ Ulcers

☐ Visual Impairment

☐ Other Disease/Illness

Type: _____

Dental History

Date of Last Dental Visit:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Date of Last Dental X-ray:

☐ I don't know exact date ☐ Last 6 months ☐ 6 months - 1 year ☐ 1-3 years ☐ Greater than 4 years ☐ Never ☐ Other: _____

Oral Health

Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No

Have you ever had Novocaine or other local anesthetic? ☐ Yes ☐ No

How happy are you with your smile (1-10)? _____

Are you currently wearing Dentures? ☐ Yes ☐ No

Age of dentures: ☐ Less Than 6 Months ☐ 6 months-3 years ☐ Greater than 4 years

Please check any conditions that apply to you below:

☐ Pain In Jaw(TMJ) ☐ Teeth Grinding/Clenching ☐ Use Tobacco Products ☐ Mouth Sores

☐ Sensitive Teeth ☐ Broken/Loose Teeth ☐ Difficulty Chewing/Swallowing ☐ Swollen/Bleeding Gums

Women Patients Only

Are you currently pregnant? ☐ Yes ☐ No Estimated Delivery Date: _____

Are you Nursing? ☐ Yes ☐ No Are you taking any birth control prescriptions? ☐ Yes ☐ No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature: _____ Date: _____

Dr's Signature/Medical History Review: _____ Date: _____

6 MONTH UPDATE

Patient's Signature:_____ Date:_____

Dr's Signature/Medical History Review: _____ Date: _____

Patient Signatures

Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance)

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Authorization for Release of Health Records to External Parties (Optional)

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____

Relationship to the Patient: _____

I give authorization to disclose the following information:

☐ all treatment information

☐ information specifically related to these treatment dates

Starting Date: _____ End Date: _____

Consent to obtain patient medication history (Optional)

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

Signature: _____ Date: _____

Payment, Insurance and Financial Arrangement Policies (signed by ALL new patients)

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

Notice of Privacy Practices (must be signed by ALL new patients)

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature: _____ Date: _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section.)

At The Aubrey Dentist, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. More than 70 million Americans don't have dental insurance today. If you're reading this, it means you belong in the other group that benefit from having dental insurance. Here are some important things you should know:

Please initial:

- _____Your dental benefits are based upon a contract made between your employer and insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- _____ We currently accept major PPO insurance plans, and all Texas Medicaid plans. This means that we work with many insurance companies with different policies, rules and updates. Therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up to date information we have, but it is ONLY AN ESTIMATE. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out-of-pocket figures you may require.
- ____ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, The Aubrey Dentist reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.
- ____ The Aubrey Dentist does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover and cash. If you are in need of an extended finance option, we also work with a third-party financing company like Sunbit & Alphaeon.
- ____ A specific amount of time is reserved especially for you, and we strongly encourage all patients to keep their appointment. If you must change your appointment, we require at least 24-hour notice to avoid a **$50 cancellation fee** (emergencies are an exception)
- **Confirmations and Cacellations:** ALL appointments must be confirmed 24 hours in advance. You will receive a text message and call 48 hours prior to the appointment. Please confirm your appointment as soon as possible after you receive the notification. ***If we don't have any notification by noon the day before the appointment, we reserve the right to cancel your appointments***. This helps our patients waiting for treatment to be seen sooner and gives them the opportunity to plan their visit. Please feel free to cancel or reschedule any appointment via text or call our office. We will be happy to assist you in scheduling another visit that accommodates better to your needs.

I agree with the above conditions.

Print Name: _____ Date:

_____ Patient/Parent

Signature: _____

Consent to Dental Examination, X-rays and Prophylaxis (Dental Cleaning)

Patient Name: _____

Date of Birth: _____

Having presented for a dental examination, I understand and consent to the examination of my head and neck, hard and soft tissues of the mouth, teeth and their supporting tissues by way of clinical examination, any necessary scan, x-rays, impressions, and photographs. I further consent to any emergency treatment that may be required, along with any referral to other members of the dental or medical team. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction.

By signing below, I agree that:

- I have read and understood the content of this form, or it was read to me.
- I have informed the dentist of any change in my medical and social histories.
- I was able to ask questions and they have been answered to my satisfaction.
- I was given the opportunity to have a support person/ an interpreter present.
- I choose to have this examination and treatment including prophylaxis (dental cleaning) done and authorize the dentist to complete the plan with his/ her designated assistants to assist with the investigation/ treatment.
- I consent to any other emergency procedure if or as required to treat an unforeseen life-threatening event during my visit or treatment.
- I confirm that I have the ability to give my informed consent to the examination/ treatment or I have the ability to give my informed consent to the examination/ treatment if signing on behalf of the patient.

Signature of the patient or a person authorized to signed on behalf of the patient,

(Patient/ Parent/ Legal Guardian)_____

Date: _____

LATE CANCELLATION / NO SHOW POLICY

Late Cancellation/No Show Policy for Dental Treatment Appointment:

At The Aubrey Dentist, your dental health is very important to us, which is why every time we book an appointment for you, we book off time in our Doctors and Dental Assistants schedule to serve you. We strive to be fully set up and ready for your appointments, and we ask that you give us the same courtesy.

We understand that there are instances when you must miss an appointment (e.g. unforeseen emergency). However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

- **Confirmations and Cacellations:** ALL appointments must be confirmed 24 hours in advance. You will receive a text message and call 48 hours prior to the appointment. Please confirm your appointment as soon as possible after you receive the notification. ***If we don't have any notification by noon the day before the appointment, we reserve the right to cancel your appointments***. This helps our patients waiting for treatment to be seen sooner and gives them the opportunity to plan their visit. Please feel free to cancel or reschedule any appointment via text or call our office. We will be happy to assist you in scheduling another visit that accommodates better to your needs.

We ask you, our patient, to give us a **minimum of 24-hour advance notice for cancellation or to re-schedule your appointment.**

- **Appointments which become No Show or Cancelled/Re-scheduled with less than 24-hour notice will be charged the following fee:**

1. **First** time - **Warning/Reminder about our Policy**
2. **Second** time - **$50.00 Fee**

The Late Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full upon receipt of the e-bill. Please note that such fees will not be covered by your insurance.

Our practice firmly believes that a good doctor/patient relationship is based upon clear understanding and communication. Questions regarding the Cancellation/Missed Appointment policy should be directed to our patient coordinators.

Patient Name: _____

Name of Parent/Guardian/Rep (if applicable): _____

Signature: _____

Date: _____