PATIENT INFORMATION

Name: ____ **Date:** ____________________
Last First MI

Birth Date: ____________________ **Please Circle:** **Male** or **Female** **Child** or **Single** or **Married**

Address: ____
Street Apartment #

____
City State Zip Code

Phone (Home): __________________ **(Work):** __________________ **(Cell):** __________________

Best Time to Call: ______________ **Email Address:** ____________________________________

Social Security #: __________________________ **Driver's License #:** __________________________

HEALTH INFORMATION (check all that apply)

- ○ AIDS
- ○ Anemia
- ○ Arthritis
- ○ Artificial Joints
- ○ Artificial Heart Valve
- ○ Asthma
- ○ Blood Disease
- ○ Bruise Easily
- ○ Cancer
- ○ Cold Sores/Fever Blisters
- ○ Contact Lenses
- ○ Cortisone Medication
- ○ Diabetes
- ○ Diet (special/restricted)
- ○ Dizziness
- ○ Emphysema
- ○ Epilepsy
- ○ Excessive Bleeding
- ○ Fainting
- ○ Glaucoma
- ○ Growths
- ○ Hay Fever
- ○ HIV Positive
- ○ Head Injuries
- ○ Heart (Attack, Disease, Surgery)
- ○ Heart Murmur
- ○ Hemophilia
- ○ Hepatitis
- ○ High Blood Pressure
- ○ Jaundice
- ○ Kidney Disease
- ○ Latex Allergy
- ○ Liver Disease
- ○ Mental Disorders
- ○ Mitral Valve Prolapse
- ○ Nervous Disorders
- ○ Other: ____________________
- ○ Pacemaker
- ○ Psychiatric/Psychological Disorders
- ○ Pregnancy (Due Date: ________)
- ○ Radiation Treatment
- ○ Respiratory Problems
- ○ Rheumatic Fever
- ○ Rheumatism
- ○ Sinus Problems
- ○ Smoke/Chew Tobacco
- ○ Stomach Problems
- ○ Stroke
- ○ Thyroid Problems
- ○ Tuberculosis
- ○ Tumors
- ○ Ulcers
- ○ Venereal Disease

Allergies to any medications (please list): ____

Are you taking any medications (please list)? ____

____

Have you been admitted to a hospital or needed emergency care during the past 2 years? YES or NO

If yes please explain: ____

Do you have any health problems that need further clarification? YES or NO

If yes please explain: ____

Are you now under the care of a physician? YES or NO

If yes please explain: ____

Name of Physician: ______________________________ **Phone #:** ______________________

DENTAL & COSMETIC INFORMATION

Previous Dentist: ____ **Date of Last Dental Visit:** ______________________

Reason for this visit today: ____

Have you ever had any complications following dental treatment? **YES** **or** **NO**

If yes please explain: ____

Is there anything about your smile that you do not like? ____

Do you like the appearance of your teeth? ____

Are all your teeth in alignment (straight)? ____

Do you have any missing teeth? **YES** **or** **NO** **Are any teeth chipped?** **YES** **or** **NO**

Is your bite comfortable when chewing or biting? **YES** **or** **NO**

Do you have frequent headaches? **YES** **or** **NO**

Do you have any old fillings or dental treatment that you are unhappy with? **YES** **or** **NO**

What would you like to change the most about the appearance of your teeth? ___________________________________

____

Is there anything else you would like us to know? ____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice (please circle)? **FRIEND** **ANOTHER DOCTOR**

DENTAL OFFICE **SCHOOL** **WORK** **OTHER:** _____________________________________

Name of person or office referring you to our practice: ____

SPOUSE or RESPONSIBLE PARTY INFORMATION

Name of Responsible Party: ____

Last First MI

Relationship to Patient (please circle)? **SELF** **SPOUSE** **PARENT/GUARDIAN**

Social Security Number: _____________________ **Birth Date:** _________________ **Driver License #:** __________________

Address: ____

Street Apartment #

____

City State Zip Code

Phone (Home): _________________________ **(Work):** ________________________ **Best Time to Call:** ________________

EMPLOYMENT INFORMATION

Employer Name: ____ **Occupation:** _________________________________

Address: ____

Street City State Zip Code

INSURANCE INFORMATION

Name of Insured: ____ **Is the insured the patient? YES or NO**

Last First MI

Insured's Birthdate: ______________________ **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 (please circle)? SELF SPOUSE CHILD OTHER:__________________

Insurance Plan Name & Telephone #: ____

CONSENT FOR SERVICES

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.
- If you cannot make it to your appointment, you need to give us a minimum of 24-hour notice for cancellation or rescheduling. If not, there will be a minimum charge of **$45** & this can go up to equal the value of the appointment.
- Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient & that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies & will credit any such collections to the patient's account. However, this dental office can't render services on the assumption that our charges will be paid by an insurance company.
- A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.
- I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) 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 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, 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 & I further agree to pay all costs & reasonable attorney fees if suit be instituted hereunder.
- Further, I understand & acknowledge that photographs & images of me may be shown to other patients & doctors for treatment & educational purposes or used in a dental publication, & I agree to the same.
- I grant my permission to you or your assignee to text, email, or 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.

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

____ **Date:** ___________________________

Signature of patient, parent or guardian

____ **Date:** ___________________________

Signature of Doctor

BUNKER HILL DENTISTRY
9807 KATY FREEWAY, SUITE 130
HOUSTON, TX 77024
(832)834-5281

PATIENT ACKNOWLEDGEMENT of RECEIPT of the NOTICE of PRIVACY PRACTICES

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and I understand that, under the Health Insurance Portability and Accountability Act of indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments physicians' certifications.

By signing this document, I acknowledge that you have provided me with a copy of your Notice of Privacy Practices. This Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information. I understand that this professional association has the right to change its Notice of Privacy Practices from time to time and that I may contact this association at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

____
Printed Patient's Name

____
Signature

____
Date