PATIENT INFORMATION

Name:_____ Date:_____

D.O.B:_____ Social Security#:_____ Driver License #_____

Address:_____

City/State/Zip Code:_____

Phone: _____ Email:_____

Please Circle: **Single** **Married** **Child** | **Male** or **Female**

Emergency Contact: _____

Relationship: _____

Phone: _____ Email: _____

HEALTH INFORMATION (check all that apply)

- o AIDS/ HIV Positive
- o Alzheimer's Disease
- o Anaphylaxis
- o Anemia
- o Angina
- o Arthritis/Gout
- o Artificial Heart Valve
- o Artificial Joints
- o Asthma
- o Blood Disease
- o Blood Transfusion
- o Breathing Problems
- o Bruise Easily
- o Cancer
- o Chemo Therapy
- o Chest Pains
- o Congenital Heart Disorder
- o Convulsions
- o Cortisone Medication
- o Diabetes
- o Drug Addiction
- o Easily Winded
- o Emphysema
- o Epilepsy or Seizures
- o Excessive Bleeding
- o Excessive Thirst
- o Fainting Spells/Dizziness
- o Frequent Cough
- o Frequent Diarrhea
- o Frequent Headaches
- o Genital Herpes
- o Glaucoma
- o Hay Fever
- o Heart Attack/Failure
- o Heart Murmur
- o Heart Pacemaker
- o Heart Trouble/Disease
- o Hemophilia
- o Hepatitis A
- o Hepatitis B or C
- o Herpes
- o High Blood Pressure
- o High Cholesterol
- o Hives/Rash
- o Hypoglycemia
- o Irregular Heartbeat
- o Kidney Problems
- o Leukemia
- o Liver Disease
- o Low Blood Disease
- o Lung Disease
- o Mitral Valve Prolapse
- o Osteoporosis
- o Pacemaker
- o Pain in Jaw Joints
- o Parathyroid Disease
- o Psychiatric Care
- o Radiation Treatment
- o Recent Weight Loss
- o Renal Dialysis
- o Rheumatic Fever
- o Rheumatism
- o Scarlet Fever
- o Shingles
- o Sickle Cell Disease
- o Sinus Trouble
- o Spina Bifida
- o Stomach/Intestinal Disease
- o Stroke
- o Swelling of Limbs
- o Thyroid Disease
- o Tonsilitis
- o Tuberculosis
- o Tumors or Growths
- o Ulcers
- o Venereal Disease
- o Yellow Jaundice

Are you allergic to any of the following?

○ Aspirin	○ Penicillin	○ Codeine	○ Acrylic	○ Local
○ Metal	○ Latex	○ Sulfa Drugs		Anesthetics

Other? (please list): _____

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

If yes please explain: _____

_____

Name of Physician: _____ Phone #: _____

Are you taking any medications (please list)? _____

_____

Have you been hospitalized or had a major operation?..... YES or NO

If yes, please explain: _____

Have you ever had a serious head or neck injury?..... YES or NO

If yes, please explain: _____

Are you taking any medications, pills, or drugs?..... YES or NO

If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux?..... YES or NO

If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ..... YES or NO

If yes, please explain: _____

Are you on a special diet? ..... YES or NO

If yes, please explain: _____

Do you use tobacco? ..... YES or NO

If yes, please explain: _____

Do you use controlled substances?..... YES or NO

If yes, please explain: _____

WOMEN:

- Are you pregnant or trying to get pregnant? ..... YES or NO
- Nursing? ..... YES or NO
- On birth control? ..... YES or NO

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

If yes, please explain: _____

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? _____

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

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: _____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party: _____ D.O.B:_____

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

EMPLOYMENT INFORMATION

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

INSURANCE INFORMATION

Insurance Name / Telephone #:_____

Name of Insured: _____ Is the insured the patient? YES or NO
Last First MI

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's Relationship to Insured (please circle)? SELF SPOUSE CHILD OTHER:_____

BUNKERHILL DENTISTRY
9807 Katy Freeway, Ste 130
Houston, TX 77024
Phone # 832-834-5281
Fax # 832-834-5343
Email- annle@bunkerhilldentistry.com / office@bunkerhilldentistry.com

FINANCIAL AGREEMENT

In order to avoid any misunderstanding regarding our financial policy, it is necessary for you to read and sign this document before treatment.

DENTAL INSURANCE: As a courtesy we will gladly file your claims provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract.
- Although we may estimate your insurance benefits, we are not responsible for their accuracy. Receiving our services indicates your acceptance of responsibility to pay regardless of your estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. If your insurance fails to pay within 60 days, you will be responsible for the balance on your account.
- Not all the services we provide are covered benefits. Benefits differ by dental plan. Fees for non-covered services along with deductibles and copayments are due at the time of service.

CANCELLATION POLICY: A fee of $100 will applied if an appointment is cancelled or broken without a 24-hour notice. We reserve the right not to make future appointments if this occurs more than twice. This fee is subject to change without notice.

PAYMENT POLICY: We accept cash, personal checks, and credit cards.

LATE FEES: 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 have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____

Signature of patient, parent, or guardian

_____ Date: _____

Signature of witness

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified on your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email or send a text to you to confirm appointments? YES or NO

May we leave a message on your answering machine at home or on your cell phone? YES or NO

May we discuss your dental conditions with any member of your family? YES or NO

If YES, please name the family members allowed:

_____

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness:_____ Date: _____

BUNKERHILL DENTISTRY
9807 Katy Freeway, Ste 130
Houston, TX 77024
Phone # 832-834-5281
Fax # 832-834-5343
Email- annle@bunkerhilldentistry.com / office@bunkerhilldentistry.com

Insurance Clarification and Policy

We always try our very best to work with your dental insurance in order to obtain fair and correct reimbursement from them. However, please keep in mind that insurance coverage and reimbursement are never guaranteed and that we cannot force them to pay.

You may not realize how much time and effort we must put in every day into our dealing with all insurance companies on your behalf. For example, just to simply verify your coverage, our staff member can be put on hold for up to 2 hours since most calling centers are not in the United States.

Regarding treatment estimates, they are purely just "estimates!" Also, Insurance may confirm that they have received the claims, but we do not get paid until at least 30 to 60 days after we have submitted the claims. Therefore, please be patient and do not call us about a claim unless it has been 60 days since you had the treatment rendered.

Finally, if your insurance refuses to pay for any services already rendered, you will have to pay us for the services rendered within 30 days.

Thank you.

Dr Tri M Le

X_____

(Please sign above)