LAWS FAMILY DENTAL

Patient Health History

Patient's Name _____ Date of last physical _____

Are you under a doctor's care? Yes No If yes, for what? _____

Medical Doctor _____ Phone Number _____

Are you taking any medication now? Yes No If so, what? _____

Do you have or have you ever had (circle yes or no):

Abnormal Bleeding	Yes	No	High Blood Pressure	Yes	No
Bruise Easily	Yes	No	Low Blood Pressure	Yes	No
Required a Blood Transfusion	Yes	No	Hepatitis, or Jaundice	Yes	No
Rheumatic Heart Disease	Yes	No	Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Stroke	Yes	No
Scarlet Fever	Yes	No	Diabetes	Yes	No
Heart Defect/Surgery	Yes	No	Cancer / Leukemia	Yes	No
Heart Attack/Angina	Yes	No	Chemotherapy	Yes	No
Heart Murmur	Yes	No	Epilepsy	Yes	No
Shortness of Breath	Yes	No	AIDS or HIV	Yes	No
Joint Replacement	Yes	No	Tuberculosis	Yes	No
Implants	Yes	No	Sinus Trouble	Yes	No
Pacemaker	Yes	No	Asthma or Hay Fever	Yes	No
Thyroid Problems	Yes	No	Stomach Ulcer	Yes	No
Kidney Trouble	Yes	No	Anemia	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No
Cold Sores / Fever Blisters	Yes	No	Eating Disorder	Yes	No
Tumors	Yes	No	Fainting or Dizzy Spells	Yes	No
Chemical Dependency	Yes	No			

Are you Allergic To (circle yes or no):

Codeine	Yes	No	Barbiturates	Yes	No
Penicillin	Yes	No	Sleeping Pills	Yes	No
Sulfa Drugs	Yes	No	Aspirin	Yes	No
Any antibiotics	Yes	No	Ibuprofen	Yes	No
Any Dental Products	Yes	No	Anesthetic	Yes	No

Women Only (circle yes or no):

Are you pregnant or think you could be?	Yes	No
Are you nursing?	Yes	No
Are you taking birth control?	Yes	No

Dental History(circle yes or no):

Do you clench or grind your teeth?	Yes	No
Do your gums bleed when you brush or floss?	Yes	No
Are your teeth sensitive to hot or cold?	Yes	No
Do you use any type of tobacco Products?	Yes	No
Have you every had periodontal treatment?	Yes	No

Do you have any disease, condition, or medical problem not listed above that you think I should know about? Yes No

If so, what? _____

Patient or Guardian Signature _____ Date _____

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LAWS FAMILY DENTAL

FINANCIAL POLICY

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

Dental Insurance

We Cannot Guarantee any estimated coverage. Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company. **If for some reason your insurance has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time. Finance charges will be assessed on account over 90 days.**

Payment Options:

Check: A $25.00 fee will be assessed on all returned checks.

Credit Cards: For your convenience we accept Master Card, Visa, and American Express.

On treatment involving laboratory fees: *(crowns, bridges, dentures and veneers)* You may choose to pay 50% on the preparation date and the balance in two weeks. (See treatment plan coordinator.)

I understand that payment is due when services are rendered, unless prior arrangements have been made.

Canceled/Rescheduled/Missed Appointments:

We realize our patients have very busy schedules. We work hard to keep your wait to a minimum and find appointment times convenient for you and your family. However, all cancellations, reschedules and missed appointments (without a twenty-four (24) hour notice) are suject to 50% of the cost of the appointment. Please be considerate of our time.

Signature_____ Date_____

LAWS FAMILY DENTAL

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete discription of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and dislosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20 _____ .

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

LAWS FAMILY DENTAL
118 LOVERS LANE
BOWIE, TEXAS 76230

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____