Welcome to Family Tree Dental Care

13901 Midway Rd., Ste 106A Farmers Branch, TX 75244

Patient Information:

Patient's Name: _____

Address: _____

City, Zip Code: _____

Email address:_____

Sex: M/F SSN: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Responsible for Account/Subscriber/Guardian Information

Name: _____ Relationship to Patient: _____

SSN: _____ Insurance Name: _____

Driver's License No: _____ Employer Name: _____

Date of Birth: _____ ***Assignment of Benefits Signature**: _____

Contact Information for Emergency:

Name: _____ Relationship to patient: _____

Phone #:_____

Please tell us how you heard about our Office below:

_____

Welcome to Family Tree Dental Care

13901 Midway Rd., Ste 106A Farmers Branch, TX 75244

Smile/Periodontal Evaluation

Patient Name: _____

We would like to help you obtain the smile you always wanted and also maintain your oral health. Periodontal disease is painless- and it affects 75% of the population and often victims are unaware. It may affect your overall health. There are warning signs and the American Dental Association and our staff want you to be aware. Please take a few minutes to complete this short smile/Periodontal Evaluation form.

1. Are you pleased with the appearance of your teeth when you smile? YES NO
2. Do you have any concerns about bad breath? YES NO
3. Do your gums bleed when you brush your teeth or toothpick between them? YES NO
4. Are your gums red, swollen, or tender? YES NO
5. Are your gums pulling away from your teeth? YES NO
6. Do you see pus between your teeth and your gums when the gums are pressed? YES NO
7. Are your permanent teeth loose and separating? YES NO
8. Is there any change in the way your teeth fit together when you bite? YES NO
9. Do you have any old fillings or dental work that you don't like? YES NO
10. Have you ever considered Orthodontic treatment (Braces)? YES NO
11. What would you change (if anything) about your smile?

_____

Welcome to Family Tree Dental Care

13901 Midway Rd., Ste 106A Farmers Branch, TX 75244

Insurance and Financial Policy

- Your dental benefits are based upon a contract between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefits plans will never pay for completion of your dental care. It is only meant to assist you.** (_____)

- We currently accept all private care insurance plans (plans that do not require selecting a dentist from a list or require our office to accept a reduced fee for service). This means that we work with thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; 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 benefits, 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, Family Tree Dental Care 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**. (_____)

- Family Tree Dental Care does require payment **in full** for your portion at the time of service. We accept MasterCard, Visa, cash and checks (for existing patients with established payment history). **We do not accept checks for over $500.00 for any patient.** If you are in need of an extended finance option, we also work with *CareCredit and Citi HealthCard,* who offers 12, 24, 36, 60 month longer terms with an interest bearing revolving charge designed to meet your treatment plans needs on approved credit. (_____)

- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change appointment, we require **at least a 24 hour** notice to avoid a **$25.00 cancellation fee** per occurrence. After the third cancelled and/or rescheduled appointment in less than 24 hours, Family Tree Dental Care reserves the right to dismiss the patient(s). In such case Family Tree Dental Care will issue a written Statement of Dismissal and will thereafter only offer emergency care for 30 days following dismissal date. *All fees accrued and balance of patient(s)'s must be paid in full within the aforementioned 30 days. It will be the patient(s)'s responsibility to locate alternative dental care.* (_____)

- Your dental records, legally, belong to you. However, our office is paperless, and we require a fee for reproducing the records. **We will be happy to email or print your records at the office fee of $25 per occurrence.** (_____)

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visit here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understood, and will abide by the above Insurance and Financial Policy.

Print Name: _____ **Date: _____**

Signature of Patient/Parent/Legal Guardian: _____

Family Tree Dental Care Health History

Patient Name: _____ Birth Date: _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. **Yes No** **Are you allergic to any medications?** _____
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last Dental exam? _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Bleeding gums?
15.	Yes	No	Anxiety?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Toothache?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, medications, latex?	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	50.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	No	Alcohol?

Please list:_____

_____

VI. WOMEN ONLY:

65.	Yes	No	Are you or could you be pregnant or nursing?	66.	Yes	No	Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date: _____

RECALL REVIEW:

1. Dentist signature_____ Date: _____
2. Dentist signature_____ Date: _____

HIPPA- PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RULES

I have received a copy of the Notice of Privacy Practices of Family Tree Dental Care.

I further understand that the practice will offer me an update to this Notice of Privacy Practice should it be amended, modified or changed in any way.

OPTING OUT:

- I do not want appointment reminder ***messages*** left on my phone. I understand that the office may charge me should I fail to keep my appointment.
- I do not want to receive appointment reminder ***text messages***. I understand that the office may charge me should I fail to keep my appointment.
- I do not want to receive ***email*** appointment reminders. I understand that the office may charge me should I fail to keep my appointment.
- I do not wish my protected health care information to be released to the following persons_____ _____

AUTHORIZATIONS:

- I give full authorization to the following persons to retrieve my **dental health information, appointment time and date, account balances, treatment plans and insurance activity**:_____ _____

Please print your name: _____

Please sign: _____ Date: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT