BASIC INFORMATION
MUST COMPLETE ALL SECTIONS!!

NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

E-MAIL _____

PATIENT OR PARENT'S EMPLOYER _____

HOW DID YOU HEAR ABOUT US? _____

DO YOU HAVE ANY MAJOR LIFE EVENTS COMING UP? YES NO
WEDDINGS, GRADUATIONS, FUNERALS, Etc? PLEASE EXPLAIN:
_____

DO YOU HAVE DENTAL INSURANCE? YES NO

ARE YOU FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT? YES NO
IF NO PLEASE FILL OUT BELOW ABOUT THE RESPONSIBLE PARTY ⬇

YOUR DATE OF BIRTH
_____

YOUR CELL PHONE NUMBER
_____

YOUR SECONDARY PHONE NUMBER
_____

YOUR SOCIAL SECURITY NUMBER

CIRCLE WHICH ONE APPLIES TO YOU?

MINOR SINGLE MARRIED

DIVORCED WIDOWED SEPERATED

YOUR EMERGENCY CONTACT INFO

Name: _____

Phone #: _____

FINANCIALLY RESPONSIBLE PARTY

NAME OF THE PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT
_____

RELATIONSHIP TO PATIENT _____

DATE OF BIRTH OF THIS PERSON: _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

E-MAIL _____

THIS PERSON'S SOCIAL SECURITY NUMBER: _____

THEIR CELL PHONE NUMBER
_____

THEIR SECONDARY PHONE NUMBER

INSURANCE INFORMATION

NAME OF THE MAIN SUBSCRIBER ON THE INSURANCE POLICY

_____

THEIR DATE OF BIRTH _____

THEIR SOCIAL SECURITY NUMBER _____

WHAT IS YOUR RELATIONSHIP TO THE MAIN SUBSCRIBER ON THE POLICY? PLEASE CIRCLE ONE OF THE BELOW

SELF SPOUCE CHILD FATHER MOTHER BROTHER SISTER OTHER: _____

INSURANCE PO BOX ADDRESS (ON THE INSURANCE CARD OR YOUR POLICY)
PO BOX # : _____

CITY _____ STATE _____ ZIP _____

NAME OF THE INSURANCE COMPANY

_____

IS THIS A PPO DENTAL INSURANCE?
YES NO

INSURANCE MEMBER ID NUMBER

_____

INSURANCE GROUP NAME

_____

INSURANCE GROUP NUMBER

_____

INSURANCE CUSTOMER SERVICE PHONE NUMBER

_____

ADDITIONAL INSURANCE INFORMATION

DO YOU HAVE A SECOND DENTAL INSURANCE? YES NO

NAME OF THE MAIN SUBSCRIBER ON THE INSURANCE POLICY

_____

THEIR DATE OF BIRTH _____

THEIR SOCIAL SECURITY NUMBER _____

WHAT IS YOUR RELATIONSHIP TO THE MAIN SUBSCRIBER ON THE POLICY? PLEASE CIRCLE ONE OF THE BELOW

SELF SPOUCE CHILD FATHER MOTHER BROTHER SISTER OTHER: _____

INSURANCE PO BOX ADDRESS (ON THE INSURANCE CARD OR YOUR POLICY)
PO BOX # : _____

CITY _____ STATE _____ ZIP _____

NAME OF THE INSURANCE COMPANY

_____

IS THIS A PPO DENTAL INSURANCE?
YES NO

INSURANCE MEMBER ID NUMBER

_____

INSURANCE GROUP NAME

_____

INSURANCE GROUP NUMBER

_____

INSURANCE CUSTOMER SERVICE PHONE NUMBER

_____

REFERRAL

FOR EVERY PATIENT YOU REFER TO US, WE WILL CREDIT YOUR ACCOUNT **$50** TOWARDS YOUR DENTAL TREATMENT AFTER THAT PERSON COMES IN AND GETS DENTAL TREATMENT!!!!

DO YOU HAVE ANYONE IN MIND WE CAN CALL? YES NO

THEIR NAME

_____

THEIR CELL PHONE NUMBER

_____

ADDITIONAL FAMILY MEMBER

NAME OF THE PATIENT _____

IS THIS PATIENT A MINOR UNDER 18 YEARS ONLY AND UNDER YOUR CARE AS A PARENT/LEGAL GUARDIAN? **YES** **NO**

IF UNDER 18 YEARS OLD, WRITE THE NAME OF THE PARENT/LEGAL GUARDIAN WHO MAKES HEALTHCARE DECISIONS ABOUT THIS PATIENT.

_____

DOES THIS PATIENT HAVE INSURANCE? **YES** **NO**

IS THIS PATIENT ON SAME INSURANCE PLAN AS THE MAIN PATIENT?

YES **NO**

IF NO, PLEASE PROVIDE THE INSURANCE INFO IF ANY AVAILABLE:

NAME OF INSURED _____

NAME OF INSURANCE COMPANY _____

GROUP NUMBER _____

INSURANCE PHONE NUMBER _____

RELATIONSHIP TO MAIN PATIENT

_____

BIRTH DATE

_____

SOCIAL SECURITY NUMBER

_____

CELL-PHONE

_____

E-MAIL

_____

ADDITIONAL FAMILY MEMBER

NAME OF THE PATIENT _____

IS THIS PATIENT A MINOR UNDER 18 YEARS ONLY AND UNDER YOUR CARE AS A PARENT/LEGAL GUARDIAN? **YES** **NO**

IF UNDER 18 YEARS OLD, WRITE THE NAME OF THE PARENT/LEGAL GUARDIAN WHO MAKES HEALTHCARE DECISIONS ABOUT THIS PATIENT.

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DOES THIS PATIENT HAVE INSURANCE? **YES** **NO**

IS THIS PATIENT ON SAME INSURANCE PLAN AS THE MAIN PATIENT?

YES **NO**

IF NO, PLEASE PROVIDE THE INSURANCE INFO IF ANY AVAILABLE:

NAME OF INSURED _____

NAME OF INSURANCE COMPANY _____

GROUP NUMBER _____

INSURANCE PHONE NUMBER _____

RELATIONSHIP TO MAIN PATIENT

_____

BIRTH DATE

_____

SOCIAL SECURITY NUMBER

_____

CELL-PHONE

_____

E-MAIL

_____

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- For patients with Dental Insurance:
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are **ultimately your responsibility**.
  Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 48-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $80.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $80 cancellation fee will be assessed for the first individual and $50 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**
- Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- Treatment appointments made that **exceed $500.00 will require 25% down** to hold the appointed time.

CONSENT

I have read and understood all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Signature_____(Patient, Parent or Guardian)

Health Insurance Portability and Accountability Act Notice

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at (469) 367 0266.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment, we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Atlas Cosmetic & Family Dentistry of Plano does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment. Safeguarding Your Personal & Health Information.

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Atlas Cosmetic & Family Dentistry of Plano maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Atlas Cosmetic & Family Dentistry of Plano.

The State of Texas requires that anyone who is prescribed a controlled substance (narcotic) will have their information entered into a nationwide database. The Drug Prescription Monitoring database is very secure, as only physicians and law enforcement can access the database. If you do not wish to have your information entered into this database, please inform the doctor and he will prescribe you a non-narcotic.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Atlas Cosmetic & Family Dentistry of Plano occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

Signature: _____ Date: _____

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended by your dentist. This form is intended to provide you with an overview of potential risks and complications. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks and complications of the recommended procedure, alternative treatment options or the option of no treatment.

It is very important that you provide Atlas Cosmetic and Family Dentistry of Plano with an accurate medical history before, during and after treatment. It is equally important that you follow your Dentist's advice and recommendations regarding medications, before and after treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your Dentist, you may increase the chances of a poor outcome. Please read the items below and sign at the bottom of the form. **Do not sign this form or agree to treatment until you have read, understood and accepted each item carefully. Be certain your dentist has addressed all of your concerns to your satisfaction before commencing treatment.**

During your course of treatment, the following care may be provided to you:

• **EXAMINATIONS AND X-RAYS** Radiographs are required to complete your examination, diagnosis and treatment plan. A periodic examination will be provided at all routine cleanings to evaluate your teeth for decay, gum disease, oral cancer and overall health. The dentist will read and diagnose any x-rays taken. In the state of Texas, a dental hygienist ***cannot*** diagnose a patient.

• **DENTAL PROPHYLAXIS (CLEANING)** A routine dental prophylaxis involves the removal of plaque and calculus ***above the gum line*** and will not address gum infections below the gum line called periodontal disease. Some bleeding after a cleaning can occur, however, should it persist and if it is severe in nature the office should be contacted.

• **PERIODONTAL TREATMENT** Periodontal disease is an infection causing gum inflammation and/or bone loss that can lead to tooth loss. At times when a routine cleaning is scheduled, the dentist may discover periodontal disease is present in all or certain areas of your mouth. If you present with an infection during your routine cleaning appointment it may be necessary for more extensive treatment to be performed. The dentist will stop the routine cleaning and explain to you the alternative treatment plans including nonsurgical cleaning ***below the gum line (Deep Cleaning)***, placement of an antibiotic or antimicrobial below the gum line or a gross debridement (two-part cleaning). If further treatment such as gum surgery and/or extractions are necessary, a comprehensive periodontal exam will be scheduled with our dentist. **The success of any periodontal treatment depends in part on your efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow any other recommendations.** Some bleeding after

deep cleanings or scaling under the gum line can occur, however, should it persist and if it is severe in nature, the office should be contacted. Untreated periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. I understand and accept the financial responsibility for such adjustments made to the treatment plan.

Allergies/Medication

I have informed Atlas Cosmetic and Family Dentistry of Plano of any known allergies I may have. I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs.

I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic or medication that may have been given to me in the office for my care. I understand that failure to take medications prescribed to me as directed may offer risks of continued or aggravated infection, pain or a negative result on the outcome of my treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

Consent

I have read each paragraph above and consent to recommended treatment as needed. I understand the anticipated benefits and commonly known risks and complications of each procedure.

Patient Full Name: _____

Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the co-payment and Deductible, which is the amount not covered by your insurance company, at the time we provide service to you.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice/ We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

_____ _____

Signature of Patient/Responsible Party Date

909 W Spring Creek Pkwy, Suite 490, Plano, TX, 75023

Office Phone Number: (469) 367 0266 Office Fax Number: (469) 649 1291

PATIENT MEDICAL HISTORY

PATIENT FULL NAME _____

PARENT/LEGAL GUARDIAN FULL NAME _____

ARE YOU UNDER THE CARE OF A PHYSICIAN YES NO

MEDICAL DOCTOR NAME _____

DATE OF LAST MEDICAL EXAM _____

HAVE YOU BEEN HOSPITALIZED OR HAD SURGERIES IN THE LAST SIX YEARS? YES NO

DO YOU USE TOBACCO? YES NO

DO YOU USE ALCOHOL? YES NO

DO YOU USE RECREATIONAL DRUGS? YES NO

DO YOU WEAR CONTACTS? YES NO

DO YOU HAVE ANY ALLERGIES? YES NO

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL, OR ANY OTHER MEDICATIONS CONTAINING BISPHOSPHONATES? YES NO

HAVE YOU EVER HAD A RADIATION THERAPY DONE TO YOUR HEAD OR NECK FOR CANCER TREATMENT? YES NO

HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

ASPIRIN	YES	NO
PENICILLIN	YES	NO
CODEINE	YES	NO
ACRYLIC	YES	NO
METAL	YES	NO
LATEX	YES	NO
SULFA DRUGS	YES	NO

ANY OTHER ALLERGIES: _____

_____

_____

Atlas Cosmetic & Family Dentistry OF PLANO

MEDICAL DOCTOR PHONE NUMBER

_____

WOMEN ONLY:

ARE YOU PREGNANT? YES NO

ARE YOU NURSING? YES NO

ARE YOU TAKING BIRTH CONTROL PILLS? YES NO

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF:					(*MARK ALL ANSWERS WITH A YES OR NO)*
	YES	NO		YES	NO	
HIGH BLOOD PRESSURE	___	___	FREQUENTLY TIRED	___	___	ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION.
HEART ATTACK	___	___	ANEMIA	___	___	
RHEUMATIC FEVER	___	___	EMPHYSEMA	___	___	YES NO
SWOLLEN ANKLES	___	___	CANCER	___	___	
FAINING/SEIZURES	___	___	ARTHRITIS	___	___	PLEASE WRITE ALL MEDICATIONS:
ASTHMA	___	___	JOINT REPLACEMENT	___	___	
LOW BLOOD PRESSURE	___	___	CHEST PAINS	___	___	
EPILEPSY/CONVULSIONS	___	___	SHORT OF BREATH	___	___	
LEUKEMIA	___	___	STROKE	___	___	
DIABETES	___	___	HAY FEVER/ALLERGIES	___	___	
HEART DISEASE	___	___	TUBERCULOSIS	___	___	
CARDIAC PACEMAKER	___	___	RADIATION THERAPY	___	___	
HEART MURMER	___	___	GLAUCOMA	___	___	
ANGINA	___	___	LIVER DISEASE	___	___	
KIDNEY DISEASE	___	___	HEPATITIS A, B OR C	___	___	
AIDS/HIV INFECTION	___	___	ULCERS	___	___	
STD'S	___	___	RESPIRATORY PROBLEMS	___	___	
THYROID PROBLEMS	___	___				

ANY OTHER MEDICAL CONDITIONS:

PATIENT DENTAL HISTORY

1. **DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?** _____
2. **ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?** _____
3. **ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?** _____
4. **DO YOU FEEL PAIN IN ANY OF YOUR TEETH?** _____
5. **DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH?** _____
6. **HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW?** _____
7. **DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE?** _____
8. **DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE?** _____
9. **DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH?** _____
10. **DO YOU HAVE DIFFICULTY CHEWING?** _____
11. **DO YOU HAVE FREQUENT HEADACHES?** _____
12. **DO YOU CLENCH OR GRIND YOUR TEETH?** _____
13. **DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?** _____
14. **HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK?** _____
15. **HAVE YOU EVER HAD BRACES?** _____
16. **HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH?** _____
17. **HOW OFTEN DO YOU FLOSS?** _____
18. **DO YOU USE A MANUAL BRUSH OR ELECTRIC?** _____
19. **DO YOU USE ANY TYPE OF MOUTH RINSE?** _____

WHAT ARE YOUR GOALS FOR YOUR MOUTH, TEETH AND SMILE?

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

_____ _____

PATIENT SIGNATURE **DATE**

_____

PRINT NAME

_____

DENTIST SIGNATURE

_____

DATE

_____

WITNESS SIGNATURE

_____

DATE