Parkway Dental Care & Orthodontics

WELCOME

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2380 Firewheel Parkway, Suite 900, Garland, TX 75040
469-587-6364

PATIENT INFORMATION

Date: _____

SS/HIC/Patient ID #: _____

Patient: _____

Address: _____

City: _____

State: _____ Zip: _____

E-mail: _____

Sex: ○M ○F Age: _____

Birthdate: _____

○Married ○Widowed ○Single ○Minor

○Separated ○Divorced ○Partnered for _____ years

Occupation: _____

Patient Employer/School: _____

Employer/School Address:

_____

Employer/School Phone: _____

Spouse's Name: _____

BirthDate: _____

SS#: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

Is patient covered by additional insurance? ○Yes ○No

Subscriber's Name: _____

Birthdate: _____ SS#: _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

ASSIGNMENT AND RELEASE

I certify that I. and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services This consent will end when my current treatment plan is completed or one year from the dale signed below.

_____
Signature of Patient, Parent Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home: _____ Work: _____ Ext: _____ Cell Phone: _____

Spouse's Work: _____ Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name: _____ Relationship: _____ Home Phone: _____ Work Phone: _____

DENTAL HISTORY

Reason for today's visit: _____ Former Dentist: _____

City/State: _____ Date of last dental visit: _____ Date of last dental visit: _____

Place a mark on "**yes**" or "**no**" to indicate if you have had any of the following:

Bad breath	○Yes ○No	Foreign objects	○Yes ○No	Periodontal treatment	○Yes ○No
Bleeding gums	○Yes ○No	Grindteeth	○Yes ○No	Sensitivity to cold	○Yes ○No
Blisters on lips or mouth	○Yes ○No	Gums swollen or tender	○Yes ○No	Sensitivity to heat	○Yes ○No
Burning sensation on tongue	○Yes ○No	Jaw pain or tiredness	○Yes ○No	Sensitivity to sweets	○Yes ○No
Chew on one side of mouth	○Yes ○No	Lip or cheek biting	○Yes ○No	Sensitivity when biting	○Yes ○No
Cigarette, pipe. or cigar smoking	○Yes ○No	Loose teeth or broken fillings	○Yes ○No	Sores or growths in your mouth	○Yes ○No
Clicking or popping jaw	○Yes ○No	Mouth breathing	○Yes ○No	How often do you floss?	_____
Dry Mouth	○Yes ○No	Mouth pain, brushing	○Yes ○No	How often do you brush?	_____
Fingernail biting	○Yes ○No	Orthodontic treatment	○Yes ○No		
Food collecting between teeth	○Yes ○No	Pain around ear	○Yes ○No		

HEALTH HISTORY

Physician's Name: _____ **Date of last visit:** _____

Have you ever taken any of the group of drugs collectively referred to as 'fen-phenr These include combinations of lonimin. Adipex. Fastin (brand names of phentermine), Pondimin (fenfluramin e) and Redux (dexfenfluramine). ○Yes ○No

Place a mark on "**yes**" or "**no**" to indicate if you have had any of the following:

AIDS/HIV	○Yes ○No	Epilepsy	○Yes ○No	Respiratory Disease	○Yes ○No
Anemia	○Yes ○No	Fainting or dizziness	○Yes ○No	Rheumatic Fever	○Yes ○No
Arthritis, Rheumatism	○Yes ○No	Glaucoma	○Yes ○No	Scarlet Fever	○Yes ○No
Artificial Heart Valves	○Yes ○No	Headaches	○Yes ○No	Shortness of Breath	○Yes ○No
Artificial Joints	○Yes ○No	Heart Murmur	○Yes ○No	Sinus Trouble	○Yes ○No
Asthma	○Yes ○No	Heart Problems	○Yes ○No	Skin Rash	○Yes ○No
Back problems	○Yes ○No	Hepatitis Type: _____	○Yes ○No	Special Diet	○Yes ○No
Bleeding abnormally, with extractions or surgery	○Yes ○No	Herpes	○Yes ○No	Stroke	○Yes ○No
Blood Disease	○Yes ○No	High Blood Pressure	○Yes ○No	Swollen Feet or Ankles	○Yes ○No
Cancer	○Yes ○No	Jaundice	○Yes ○No	Swollen Neck Glands	○Yes ○No
Chemical Dependency	○Yes ○No	Jaw Pain	○Yes ○No	Thyroid Problems	○Yes ○No
Chemotherapy	○Yes ○No	Kidney Disease	○Yes ○No	Tonsillitis	○Yes ○No
Circulatory Problems	○Yes ○No	Liver Disease	○Yes ○No	Tuberculosis	○Yes ○No
Congenital Heart Lesions	○Yes ○No	Low Blood Pressure	○Yes ○No	Tumor or growth on head or neck	○Yes ○No
Cortisone Treatments	○Yes ○No	Mitral Valve Prolapse	○Yes ○No	Ulcers	○Yes ○No
Cough, persistent or bloody	○Yes ○No	Nervous Problems	○Yes ○No	Venereal Disease	○Yes ○No
Diabetes	○Yes ○No	Pacemaker	○Yes ○No	Weight loss, unexplained	○Yes ○No
Emphysema	○Yes ○No	Psychiatric Care	○Yes ○No		
Do you wear contact lenses?	○Yes ○No	Radiation Treatment	○Yes ○No		

WOMEN

Are you pregnant? ○Yes ○No Due date: _____ Are you nursing? ○Yes ○No Taking birth control pills? ○Yes ○No

MEDICATION

List any medications you are currently taking and the correlating diagnosis:

_____

Pharmacy Name: _____

Phone: _____

ALLERGIES

- ☐Aspirin
- ☐Barbiturates (Sleeping pills)
- ☐Codeine
- ☐Iodine
- ☐Latex
- ☐Local Anesthetic
- ☐Penicillin
- ☐Sulfa
- ☐Other _____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ○Yes ○No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature: _____ Doctor's Signature: _____

Date: _____ Date: _____

Has there been any change in your health since your last dental appointment? ○Yes ○No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature: _____ Doctor's Signature: _____

Date: _____ Date: _____

HIPAA 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 description 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 the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed 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 dare I revoke this consent is not affected.

Print Patient Name: _____ Relationship to Patient: _____

Email: _____ Phone Number: _____

_____ _____

Signature Date

Financial Agreement

Thank you for choosing us to provide your dental care We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits 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. Our relationship is with you and not your insurance company
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy Knowledge of benefits as well as benefit amounts, limitations, exclusions. waiting periods. etc is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for noncovered services, along with deductibles and copayments are due at the time of treatment

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, MasterCard and Discover
- After dental insurance has paid its portion. a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 30 days of the statement date, to avoid finance charges.
- We do not file claims for medical insurance or more than one dental insurance company per patient.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees. and payment is expected at each visit for services rendered.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 48 hours notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to additional fees Broken appointments prevent others from receiving the dental care they deserve We take them seriously so please be considerate and inform us in advance if you need to change: your appointment.

FEE FOR MISSED APPOINTMENT IF 48-HOUR NOTICE NOT GIVEN: Each time a patient misses an appointment without providing proper notice. another patient loses an opportunity to receive timely care. If you are unable to keep your appointment, we respectfully ask that you notify our clinic at least 48 hours in advance. Failure to cancel/reschedule an appointment that you do not attend will be considered a missed appointment or no show.

Due to high patient demand, and limited availability of appointments we have instituted a **$50 no show fee for weekdays and $75 for appointments made for either Saturdays or for the day before or the day after Holidays***. As of July 1st, 2013, you must give 48 hour advanced notice to cancel/reschedule appointments. Failure to do so will result in a **$50/$75 fee** charged to your account. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A $30.00 charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 30 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your record or radiographs.

We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

CONSENT & AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Parkway Dental Care. Without any reservations, I agree to abide by the policies outlined herein.

Patient Name: _____ Parent/Guardian's Name: _____

Email: _____ Phone number: _____

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent or Guardian Date

***Holidays are New Year's Day, Independence Day, Thanksgiving Day and Christmas Day**