Patient Information

Patient Name: ____ Date: ___________
Last, First MI (Preferred Name)

☐ male ☐ female ☐ single ☐ married ☐ child ☐ other

Social Security______________________ Birth Date _____/_____/_______ State ID/TXDL#_______________

Phone (Home): ______________ (Work)_____________ Ext:______ (Cell)______________ (Preferred#)______________

Email address: ____

Mailing Address:____
Street Apartment #

____
City State Zip Code

Health History

Have you ever had any of the following? Please check those that apply:

☐ Heart Attack _______
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Heart Surgery______
☐ Artificial Heart Valve
☐ Pacemaker
☐ Artificial Joints
  ☐ Knee/Hip
  ☐ Other _________
☐ Diabetes
☐ Kidney Disease
☐ Kidney Transplant
☐ Immunosuppressant Drugs
☐ Immune Deficiencies
☐ HIV/AIDS
☐ Rheumatism/Arthritis
☐ High Blood Pressure
☐ Stroke
☐ Glaucoma
☐ Tuberculosis
☐ Sleep Apnea

☐ Cancer_____________
  ☐ Radiation Treatment
  ☐ Chemotherapy
  ☐ Surgery___________
☐ Benign Growths_________
☐ Excessive Bleeding
☐ Hemophilia
☐ Liver Disease
☐ Hepatitis
  ☐ Hep A/B
  ☐ Hep C
☐ Jaundice
☐ Anemia
☐ Hyperthyroid
☐ Low Thyroid
☐ COPD
☐ Emphysema
☐ Asthma
☐ Sinus Problems
☐ Seasonal Allergies
☐ Seizures/Epilepsy
☐ Excessive Daytime Sleepiness

☐ Depression
☐ Anxiety
☐ Mental Disorders
  ☐ ADD / ADHD
  ☐ Other________
☐ Stomach Problems
  ☐ GERD
  ☐ Other________
☐ Ulcers
☐ Intestinal Disorders
☐ Alzheimer's
☐ Parkinson's
☐ Venereal Disease
☐ Fainting
☐ Pregnancy -currently DUE DATE________
☐ Hospitalized
____
☐ Bisphosphonate class of medications
☐ Osteoporosis
☐ OTHER MEDICAL

DRUG ALLERGIES
☐ Penicillin Allergy
☐ Clindamycin Allergy
☐ Erythromycin Allergy
☐ Tetracycline Allergy
☐ Codeine Allergy
☐ Hydrocodone Allergy
☐ Aspirin Allergy
☐ Ibuprofen Allergy
☐ Anesthetic Allergy Type ___________

OTHER ALLERGIES
☐ Latex
☐ Adhesives
☐ Acrylics
☐ Metals
☐ Black Rubber
☐ Food Allergies
☐ Other

Please list the medications you take:

______________________. ______________________.
______________________. ______________________.
______________________. ______________________.
______________________. ______________________.

Your Weight_____lbs
Your Height________

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____

  Name of Physician: ____ Phone: ________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I consent to treatment by the doctor and her staff as deemed necessary and appropriate.

____ Date: ___________________
Signature of patient, parent or guardian

Dental History

Primary Reason for appointment:

☐ Comprehensive Exam ☐ Cosmetic Dentistry/Esthetic Consultation ☐ Invisalign Consultation ☐ Emergency

Do you have a specific dental problem you would like addressed?

☐ yes Please describe:____

☐ no

When was your last check up and cleaning? ______/______/________

How often do you brush? ________________

How often do you floss? ________________

Are your teeth Sensitive to: ☐ Cold ☐ Hot ☐ Sweet ☐ Biting/Chewing ☐ Touch

Do your gums bleed? ☐ yes ☐ no

Do you clench or grind your teeth? ☐ yes ☐ no

Have you noticed cracks in your teeth? ☐ yes ☐ no

Do you have clicking or popping in the jaw joint ☐ yes ☐ no

Do you have discomfort in the jaw joint ☐ yes ☐ no

Do you have any sores, ulcers or growths in your mouth ☐ yes ☐ no

Have you ever had: ☐ Scaling and Root Planing ☐ TMJ therapy/surgery ☐ Braces ☐ Gum Surgery

Do you think you have gum disease? ☐ yes ☐ no

Do you think you have cavities? ☐ yes ☐ no

Do you Smoke or chew tobacco products? ☐ yes ☐ no If yes, How much/how long? #Cigs/Packs______/day/_____yrs

Do you consume alcoholic beverages? ☐ yes ☐ no If yes, ☐ rarely ☐ less than 2/day ☐ more than 2/day

Do you use recreational drugs? ☐ yes ☐ no If yes, what type__________________________________ ______

Are you pleased with the appearance of your teeth? ☐ yes ☐ no If no, please describe__________________________

Are you interested in improving your smile? ☐ yes ☐ no

Would you like whiter teeth? ☐ yes ☐ no

Describe any other changes you would like in the appearance of your teeth: ____________________________________

____

Have your past dental experiences always been positive? ☐ yes ☐ no If no, please describe_________________________

Do you have severe fear of dental treatment? ☐ yes ☐ no

Are you interested in some type of sedation? ☐ yes ☐ no

If yes: ☐ nitrous sedation ☐ oral conscious sedation

Financial Policy

PAYMENT IS EXPECTED AT THE TIME OF SERVICE
PAYMENT MAY BE IN THE FORM OF CHECK, CASH, CREDIT CARD, OR EXPECTED INSURANCE BENEFITS

Please read and initial:

_____ Initial — As a courtesy, we will file your insurance for you and allow 30 days for insurance payment on your account. On the day of service we will collect your approximate co-pay for the services rendered. Any balance left on the account after insurance payment is received is the responsibility of the patient or financial guarantor and you will receive a bill for any remaining balance. To keep your account in good standing, please remit payment by the due date on the statement.

_____ Initial — Once the insurance company has made payment on all outstanding claims for all members on the account, if there is a credit remaining on the account, it can be refunded to you upon your request or you may choose to leave it on the account against future treatment.

_____ Initial — Treatment and fees may vary depending on your dental needs at the time of treatment.

_____ Initial — A missed appointment or late cancellation fee of $25 will be assessed for less than 48 hrs notice (2 business days).

By signing below I state that I have read, understood and agree to the above financial policy.

I also understand that I or my guarantor will be ultimately financially responsible for any balances on my account.

Patient/Parent or Guardian Signature: ______________________________________ Date_____/______/_____

State ID/TXDL# :_____________________

Guarantor Information

Responsible Party / Insurance Information

Name of Guarantor/Insured :_____________________,____
Last First MI (preferred)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________________

Social Security #: _________________________________ Birth Date: _____/_____/_______

Phone (Home): ________________ (Work): ________________ Ext: ______ (Cell#): ____________________

Email address ____

Address: ____
Street Apartment #
____
City State Zip Code

Employer Name: _____________________________________ Occupation: ______________________________

Address: ____
Street City, State Zip Code Phone

Insurance Plan Name ____

Insurance Address:____
Street City, State Zip Code

Insurance Telephone # (______) _______________________

Group ID#_____________________ Member ID#____________________

Photographic Release

In our office we like to photograph our patients for aid in determining their problems and to help come up with the perfect treatment options for them. With these photographs, we can recreate your smile on the computer so that you can see the final results and approve of them before we start any procedure.

Dr. Lowery also uses the photographs with the patient's permission to teach dentists from all over the world how we create beautiful smiles for our patients. She is a member in good standing with the AACD, the American Academy of Cosmetic Dentistry. She also plans to use the photographs to give lectures through out the country on the latest advances of dental technology.

We are very proud of the work we have done and only use our own patients in our marketing and advertising. All of the portraits in our office, on our web site, www.AveryRanchDental.com , and in our ads are our own patients and photography.

Authorization and Release

I ________________, hereby authorize Dr. Elizabeth Lowery and her staff to take photographs, slides, and / or videos of my face, jaws, and teeth. I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature: ________________________________

Date: ____________________________________

Who may we thank for referring you? ________________________.

- ☐ Avery Ranch Sign
- ☐ Insurance Web page
- ☐ Avery Ranch Website
- ☐ Neighborhood Newsletter
- ☐ New Beauty Magazine
- ☐ Avery Ranch Living
- ☐ Yelp
- ☐ Facebook
- ☐ Google Search
- ☐ Friend Referral
- ☐ Other: ________________________.

Emergency Contact List

Printed Name	Phone	Relationship to Patient
______________________________	________________	______________________
______________________________	________________	______________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION HANDED TO YOU CAREFULLY.

By signing below I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES

Signed _______________________________ Date ______/_______/__________

Printed name___________________________

(initials)______ I understand that all incoming and outgoing calls at Avery Ranch Dental are recorded for quality and training purposes.

If there is anyone to whom you would authorize Avery Ranch Dental to release your personal health and account information, please list their names and relationships below:

Printed Name	Relationship to Patient
______________________________	________________________
______________________________	________________________
______________________________	________________________