RIVER TRAILS DENTISTRY

2977 South Precinct Line Rd Suite 213
Fort Worth, TX 76118
PH: (817) 595 9600 Fax: (817) 665 9169

Please take your time to fill out all 3 pages

Patient Information

Date_____
Patient Name _____
E-Mail _____
Address _____
City _____
State Zip _____
Home Phone_____
Work Phone _____
Cell Phone _____
Birth Date_____ Age: _____
Weight: _____ Height: _____
SSN _____DL_____
Marital Status_____
Employer _____
Employer Address _____

Dental Insurance (if you have provided your insurance info then you can skip this portion.)

Policy Holder (Insured) _____
Policy Holder's Birth date _____
Policy Holder's SSN _____
Insurance Company _____
Insurance Phone # _____
Group# _____
ID# _____
Relationship to policy holder _____

Emergency Contact Name _____
Contact Phone Number _____
Relationship to Patient _____
Referral: _____
How did you hear about us?_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to Dr. Joseph 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 dentist may use my health care information and may disclose such information the above-named Insurance Company and their agents for the purpose of benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand it is my responsibility to notify the dentist whenever I have a change of insurance.

Signature of Patient, Parent, or Legal Guardian _____
Print Name as Above _____
Date _____
Relationship to Patient _____

Electronic Communication

I have read the consent form for electronic communication. I hereby authorize for the dental practice to use my email information to communicate with me electronically.

Signature of Patient, Parent, or Legal Guardian _____

Dental History

Date Of Last Dental Cleaning: _____
Date Of Last Dental X-Rays: _____
Orthodontic Treatment, _____
Periodontal Treatment: _____
How often do you brush? _____
How often do you floss? _____

Clicking Or Popping Jaw: _____
Grinding Teeth: _____
Sensitivity To Hot Or Cold: _____
Numbness in mouth: _____
Cigarette, Or Cigar Smoking: _____

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Health History

PHYSICIAN'S NAME/phone/Fax/ DATE OF LAST VISIT _____
FOR WOMEN: PREGNANT? Yes or No 1st /2nd /3rd trimester Due date: _____
BREAST FEEDING? Yes or No CONTRACEPTIVE (Birth Control)? Yes or No ASA: I, II, III, IV (Office only)

PLEASE CIRCLE "YES" OR "NO (past)" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING: * medical clearance form possibly required, if condition(s) is current.

AIDS/HIV*	YES OR NO	HEART MURMUR*	YES OR NO -> if YES: FUNCTIONAL OR
ASTHMA	YES OR NO	JAUNDICE	YES OR NO NON-FUNCTIONAL
ANEMIA	YES OR NO	JAW PAIN	YES OR NO
ARTHRITIS	YES OR NO	KIDNEY DISEASE*	YES OR NO
ARTIFICIAL HEART VALVES*	YES OR NO	LIVER DISEASE*	YES OR NO
ARTIFICIAL JOINTS*	YES OR NO	MITRAL VALVE PROLAPSE*	YES OR NO -> if YES: FUNCTIONAL OR
BLOOD DISEASE	YES OR NO	PACEMAKER*	YES OR NO NON-FUNCTIONAL
BACK PROBLEMS	YES OR NO	PSYCHIATRIC CARE	YES OR NO
BLEEDING ABNORMALLY*	YES OR NO	RESPIRATORY DISEASE	YES OR NO
CIRCULATORY PROBLEMS	YES OR NO	RHEUMATISM	YES OR NO
CHEMICAL DEPENDENCY	YES OR NO	RHEUMATIC FEVER*	YES OR NO
COUGH, PERSISTENT*	YES OR NO	STROKE*	YES OR NO
CANCER*:_____	YES OR NO	SINUS TROUBLE	YES OR NO
DIABETES Type:____	YES OR NO	SPECIAL DIET	YES OR NO
EPILEPSY*	YES OR NO	SCARLET FEVER*	YES OR NO
EMPHYSEMA*	YES OR NO	STEROID (CORTISONE Treatmt*	YES OR NO
EDEMA, SWELLING	YES OR NO	SKIN RASH	YES OR NO
FAINTING (vertigo)	YES OR NO	SHORTNESS OF BREATH (CHF*)	YES OR NO
GLAUCOMA*	YES OR NO	SWOLLEN NECK GLANDS	YES OR NO
LOW BLOOD PRESSURE	YES OR NO	TUBERCULOSIS*	YES OR NO
HIGH BLOOD PRESSURE	YES OR NO	TONSILITIS	YES OR NO
HEADACHES	YES OR NO	THYROID PROBLEMS	YES OR NO
HEART PROBLEMS*	YES OR NO	TUMOR GROWTH*	YES OR NO
HEPATITIS TYPE*_____	YES OR NO	VENEREAL DISEASE	YES OR NO
HERPES*	YES OR NO	WEIGHT LOSS	YES OR NO

Please list any **surgery** you have had in the past and date of operation: _____
_____
Do you have any **prosthesis** (ex. stents, metal screws/plates)? **YES OR NO**, IF YES, DATE OF INSERTION: ____/____/____

Has your doctor recommended **premedication**, prior to dental appointment? **Y or N**, if YES, What **Anti-biotic**:_____

MEDICATION: Yes/No

LIST ANY **MEDICATION** YOU ARE CURRENTLY TAKING AND THE CORRELATING **DIAGNOSIS**:

1) MED: _____ DIAG: _____ 2) MED: _____ DIAG: _____
3) MED: _____ DIAG: _____ 4) MED: _____ DIAG: _____
5) MED: _____ DIAG: _____ 6) MED: _____ DIAG: _____

Are you taking or have you ever taken **Bisphosphonates**?(ex. Fosomax, Actonel, Humira etc.) For osteoporosis, chemotherapy etc.? **:□Yes □No**

ALLERGIES PLEASE CIRCLE "YES" OR "NO" IF YOU ARE ALLERGIC TO:

ASPIRIN	YES OR NO	CODEINE	YES OR NO	PENICILLIN	YES OR NO	SULFA	YES OR NO
IODINE	YES OR NO	LATEX	YES OR NO	LOCAL ANESTHETIC	YES OR NO		

PLEASE LIST ANY OTHER DRUGS YOU ARE **ALLERGIC** TO: _____

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Patient Consent

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 River Trails Dentistry 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 River Trails Dentistry

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 River Trails Dentistry reserves the right to change the terms of this notice from time to time and that I may contact River Trails Dentistry at any time to obtain the more current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out the treatment, payment, and health care operations, by River Trails Dentistry (which is 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.

Payment Policy

To avoid any misunderstandings regarding insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees at the time of service. Our patients may use cash, credit card, or care credit to pay their balances. **We do not accept checks and we will collect patient's responsibility prior to procedure. We do not render our service on the basis of what our patient's insurance companies will or will not cover**. We render our services based on our patients' oral health and the best treatment to maintain and/or restore our patients' oral health.

The portion that is charged to our patient is the **estimated** amount due from the patient based on what the insurance company has conveyed over the telephone to our office staff. However, if the insurance company does not cover all of the fees, **the patient is responsible for any and all balances remaining**. We will file the primary insurance as a courtesy; however, the patient is responsible for all fees incurred. In addition to all other remedies, the patient shall pay River Trails Dentistry expenses and attorney's fees and/or any other outside collection agency fees incurred to collect money owed to River Trails Dentistry from the patient under these terms.

If you need to cancel or reschedule any appointments please allow a 24 hour advanced notice, so that we can accommodate other patients. **There will be a $50 charge to your account for any no show or cancelled appointment without a 24 hour notice.**

(When patients are requesting copies/mail of any documentation or x-rays there will be $5.00 charge for each service. For special cash exam/xray(s) will be $25.

Date: _____

Printed Patient Name: _____ Relationship to Patient: _____

Signature: _____