

Ballard Family Dentistry
ABOUT YOU

Today's Date: _____ Email Address: _____

Name: _____ I prefer to be called: _____ _ Male _ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ _ Single _ Married _ Divorced _ Widowed _ Separated

Home Address: _____
Street City State Zip

Home Phone #: (____) _____ Pager/Cell #: (____) _____ Work #: (____) _____ Driver Lic. #: _____

Where and when are the best times to reach you? _____ Whom may we thank for referring you? _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street / PO Box City State Zip

Neighbor or Relative not Living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (____) _____ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Drivers License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Medical Coverage? _ Yes _ No Dental Coverage? _ Yes _ No Orthodontic Coverage? _ Yes _ No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
Street City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employers Address: _____
Street / PO Box City State Zip

CONTINUED ON BACK

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment Yes No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ / TMD)? Yes No

Do you floss daily? Yes No Brush daily? Yes No

Do you use anything in addition to floss? Yes No
 If yes, what? _____

Would you like fresher breath? Yes No
 (ask us about Breath RX)

Whiter teeth? Yes No

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

Do you have mobility in your teeth? Yes No

Are your teeth sensitive to heat, cold, or anything else?

Do you still have wisdom teeth? Yes No

Previous / Present Dentist: _____ Last Visit Date: _____
 (please circle)

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen?

Are you happy with the way your smile looks? Yes No
 If not what would you change? _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Address: _____
 Street City Texas Zip

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

How much do you smoke or use per day? _____

Are you allergic to any of the following?

| | | |
|------------------|------------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Sedatives |
| Y N Barbiturates | Y N Jewelry / Metals | Y N Sulfa Drugs |
| Y N Codeine | Y N Latex | Y N Tetracycline |
| Y N Penicillin | Y N Dental Anesthetics | Y N Other |

Please list additional drugs / materials that cause allergic reactions:

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes No

Week #: _____ Are you nursing? Yes No

Are you taking any of the following?

- | | | | |
|--------------------|---------------------------------|------------------------------|----------------------|
| Y N Acetaminophen | Y N Blood Thinners | Y N Insulin / Diabetes Drugs | Y N Thyroid Medicine |
| Y N Antibiotics | Y N Blood Pressure Medication | Y N Nitroglycerin | Y N Tranquilizers |
| Y N Antihistamines | Y N Cold Remedies | Y N Recreational Drugs | |
| Y N Aspirin | Y N Digitalis/ Heart Medication | Y N Steroids / Cortisone | |

Are you taking any prescription / over-the-counter-drugs not listed above? Yes No If yes, please list each one: _____

Do you or have you experienced the following?

- | | | | | |
|---------------------------------|-----------------------------|------------------------------------|--------------------------|-----------------------|
| Y N Abnormal Bleeding | Y N Congenital Heart Defect | Y N Heart Surgery | Y N Pacemaker | Y N Thyroid Problems |
| Y N Alcohol Abuse | Y N Diabetes | Y N Hemophilia | Y N Persistent Cough | Y N Tonsillitis |
| Y N Anemia | Y N Difficulty Breathing | Y N Hepatitis | Y N Psychiatric Problems | Y N Tuberculosis (TB) |
| Y N Arthritis | Y N Drug Abuse | Y N Herpes | Y N Radiation Treatment | Y N Ulcers |
| Y N Artificial Bones/ Joints | Y N Emphysema | Y N High Blood Pressure | Y N Rheumatic Fever | Y N Venereal Disease |
| Y N Asthma | Y N Epilepsy | Y N HIV+ / AIDS | Y N Scarlet Fever | |
| Y N Blood Transfusion | Y N Fainting Spells | Y N Kidney Problems | Y N Seizures | |
| Y N Cancer | Y N Glaucoma | Y N Hospitalized for Any Reason | Y N Shingles | |
| Y N Chemotherapy | Y N Hay Fever | Y N Liver Disease | Y N Sickle Cell Disease | |
| Y N Chicken Pox | Y N Headaches | Y N Lupus | Y N Sinus Problems | |
| Y N Colitis | Y N Heart Attack | Y N Mitral valve Prolapse | Y N Steroid Therapy | |
| | Y N Heart Murmur | | Y N Stroke | |

Payment is Due at Time of Service

- Non-Dental benefit coverage accounts – payment in full due at time of service.
- Dental Benefit coverage accounts – estimated patient portion due at time of service.

Dental Benefits

Dental benefit coverage information is the sole responsibility of the patient/subscriber. Patient portions are **estimates** only based upon information received and due at time of service, any remaining balance after insurance pays is due upon receipt of your statement.

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the staff of Ballard Family Dentistry and/or the doctor to perform necessary dental services I may need. I have read and understand the consent for treatment form presented to me and I know that I can request a copy for my records. My method of payment will be _____.

Signature Date

I certify that I am covered by _____ Insurance Co. and I assign directly to Ballard Family Dentistry all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature Date

Patient Name: _____
Date of Birth: _____ Social Security #: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent for your review. We encourage you to read it carefully and completely before signing this Consent. We will be happy to provide you a copy for your records if you wish.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the office manager. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Consent: Parent/Guardian

I, _____ have had full opportunity to read and consider the contents of this Consent Form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient complete the following:

Guardian Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in patient's chart.**