



Conroe Family Dentistry



Patient Information:

Name _____ Spouse _____

Date of Birth _____ Social Security Number _____ Age _____ Gender _____

Address _____ City _____

State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Can we Text you? _____ Call you? _____ Email you? _____ (Yes/No: in regards to appointment reminders, insurance, treatment plans, invoices, etc)

Emergency Contact:

1st Name _____ Relationship to Patient _____

Phone number _____ Email _____

2nd Name _____ Relationship to Patient _____

Phone number _____ Email _____

Referral Source:

Who can we thank for referring you to our office? _____



Conroe Family Dentistry



Financially Responsible Contact:

Name _____ Spouse _____

Address _____ City _____

State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____

Consent for Financial Responsibility:

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred for their care.
- Patients understand that prior to treatment, a treatment plan will be provided with an **estimate** of the patient and the insurance portion. Patients also understand that in the case that insurance does not cover treatment, the patient will be fully responsible for the cost of treatment. **Patients are responsible to know their insurance plan and will be responsible for keeping track of the use of their benefits.**
- A service charge of **\$25/per hour scheduled** will be billed to patients that do NOT cancel their appointment with a 24 hour notice (No Shows)
- I have read the above conditions of treatment/payment and agree to their content. • I have provided accurate insurance/emergency/personal information and understand that I must report any changes to Conroe Family Dentistry.

Patient/Guardian Signature _____ **Date** _____

Patient Print Name _____



Conroe Family Dentistry Medical History



In order for our office to provide each patient with the best possible care, please complete the Medical & Dental history below. ALL information is completely **CONFIDENTIAL**. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you may receive. Thank you for answering the following questions.

Are you under a physician's care for a specific medical condition? Yes ___ No ___

Condition _____ Physician's Name _____ Phone # _____

Have you ever been hospitalized or had a major operation? Yes ___ No ___

If yes, explain _____

Are you currently on a special diet? Yes ___ No ___

If yes, explain _____

Do you use recreation drugs? Yes ___ No ___

If yes, explain _____

Pregnant/Trying to get pregnant? Yes ___ No ___ If pregnant, Due Date _____

Nursing? Yes ___ No ___ Taking Oral Contraceptives? Yes ___ No ___

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE BELOW CONDITIONS

(PLEASE CIRCLE ALL THAT APPLY)

- | | | | | |
|---------------------|-------------------------|--------------------|----------------------|--------------------|
| AIDS/HIV POSITIVE | ALZHEIMERS | ANAPHYLAXIS | ANEMIA | ANGINA |
| ARTIFICIAL HEART | ARTIFICIAL JOINT | ASTHMA | AUTISM/SPECTRUM | BLISTERS |
| BLOOD DISEASE | BLOOD TRANSFUSION | BREATHING ISSUES | BRUISE EASILY | CANCER |
| CHEMOTHERAPY | CHEST PAIN | COLD SORES | CONGENITAL HEART | CONVULSIONS |
| CORTISONE | COUGH (COPD/FREQUENT) | DIABETES | DIARRHEA | DISABILITY |
| DRUG ADDICTION | EASILY WINDED | EMPHYSEMA | EPILEPSY/SEIZURES | EXCESSIVE BLEEDING |
| EXCESSIVE THIRST | FAINT/DIZZY SPELLS | GENITAL HERPES | GLAUCOMA | HAY FEVER |
| HEART ATTACK | HEART DISEASE/PACEMAKER | HEMOPHILIA | HEPATITIS A, B, OR C | HERPES |
| HIGH BLOOD PRESSURE | HIVES/RASH | HYPOGLYCEMIA | IRREGULAR HEART | KIDNEY DISEASE |
| LEUKEMIA | LIVER DISEASE | LOW BLOOD PRESSURE | LUNG DISEASE | |
| MIGRAINES/HEADACHES | MITRAL VALVE PROLAPSE | PSYCHIATRIC CARE | RADIATION TREATMENT | RENAL DIALYSIS |
| RHEUMATIC FEVER | RHEUMATISM | SCARLET FEVER | SHINGLES | SICKLE CELL |
| SINUS ISSUES | SPINA BIFIDA | STOMACH/INTESTINAL | STROKE | SWELLING |
| THYROID DISEASE | TONSILITIS | TUBERCULOSIS | TUMORS/GROWTH | ULCERS |
| VENEREAL DISEASE | WEIGHT (LOSS/GAIN) | OTHER _____ | | |

Patient Name _____

Office Notes _____ Doctor Signature _____ Date _____



Conroe Family Dentistry Medical History



PLEASE LIST ANY MEDICATION (PRESCRIBED & OVER-THE-COUNTER), VITAMINS, AND SUPPLEMENTS YOU ARE CURRENTLY TAKING. IF YOU ALREADY HAVE A COPY OF YOUR MEDICATIONS WE'D BE HAPPY TO MAKE A COPY OF IT FOR OUR RECORDS.

Medications/Vitamins/Supplements	Reason for taking Medication

Are you allergic to any of the following? (circle)

Aspirin Penicillin Codeine Acrylic Latex Local Anesthetics

Other: _____

PHARMACY NAME: _____ **PHONE #:** _____

ADDRESS: _____

Patient/Guardian Signature _____ *Date* _____

Patient Print Name _____

Doctor Signature _____ *Date* _____

Office Notes



Conroe Family Dentistry Dental History



DO YOU HAVE ANY IMMEDIATE DENTAL CONCERNS NOW? YES ___ NO ___

If yes, describe _____

ARE YOU SATISFIED WITH YOUR TEETH'S APPEARANCE? YES ___ NO ___ EXPLAIN:

DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT? YES ___ NO ___

EXPLAIN: _____

Have you ever had: Are any of your teeth sensitive to:

Orthodontic Treatment? Yes ___ No ___ Hot or Cold? Yes ___ No ___

Oral Surgery? Yes ___ No ___ Sweets? Yes ___ No ___

Periodontal Treatment Yes ___ No ___ Biting/Chewing Yes ___ No ___

Teeth Ground/Bite Adjust Yes ___ No ___ Odors/Bad Taste Yes ___ No ___

Bite Plate/Mouth Guard Yes ___ No ___ Injury to Mouth/Head Yes ___ No ___

Do you have any of the following habits?

Clench or grind teeth while awake or asleep? Yes ___ No ___ Bite your lips or cheeks regularly? Yes ___ No ___

Mouth breath while awake or asleep? Yes ___ No ___ Smoke/Chew tobacco? Yes ___ No ___

Have you experienced any of the following?

Clicking or popping of the jaw? Yes ___ No ___ Pain (joint, ear, side of face)? Yes ___ No ___

Difficulty opening/closing mouth? Yes ___ No ___ Head, Neck, or Shoulder ache? Yes ___ No ___

Do your gums bleed or hurt? Yes ___ No ___

Have your parents experienced gum disease or tooth loss? Yes ___ No ___

Have you noticed any loose teeth or change in your bite? Yes ___ No ___

Does food tend to become caught in between your teeth? Yes ___ No ___

Patient Name _____

Office Notes:



Conroe Family Dentistry



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement, but, in refusing
we will not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Conroe Family Dentistry. A copy of this signed, dated document shall be as effective as the original. The American Dental Association (ADA) has revised its Notice of Privacy Practices to reflect stricter protections for Substance use disorder (SUD) records under 42 CFR Part 2. (This means that certain information- including SUD records, mental health information, HIV-related data, and genetic information-by signing our HIPPA release form you are giving consent to share). **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

Please **PRINT PATIENT's** name

PATIENT's SIGNATURE (age 18 & older)

Legal Representative Signature

Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM APPOINTMENTS, TREATMENT, & BILLING INFORMATION, RELAY INFORMATION ABOUT MY DENTAL HEALTH, AND/OR BEING CONTACTED ABOUT SPECIAL OFFERS** VIA:

- Cell phone
- Home phone
- Text message
- Email

OFFICE USE ONLY: As Privacy Officer, I attempted to obtain the patient's (or representatives signature on this Acknowledgement but did not because:

- It was an emergency treatment
 - I could not communicate with the patient
 - Patient refused to sign
 - Other: _____

Signature of Privacy Officer: _____ Date: _____