

# WELCOME

## 1

### ABOUT YOU

Today's Date : \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File # : \_\_\_\_\_

Patient Name: \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS# \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: ( ) \_\_\_\_\_

Work Phone #: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

Status:  Minor  Single  Married  Male  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Do you have children?  Yes  No How Many? \_\_\_\_\_

## 2

### INSURANCE INFO

Primary Dental Insurance

Co. Name : \_\_\_\_\_

Address: \_\_\_\_\_  
CITY STATE ZIP

Phone #: ( ) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group# (Plan, Local, or Policy#) : \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

Secondary Dental Insurance

Co. Name : \_\_\_\_\_

Address: \_\_\_\_\_  
CITY STATE ZIP

Phone #: ( ) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group# (Plan, Local, or Policy#) : \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

## 3

### ACCOUNT INFO

Person ultimately responsible for account

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

SS#: \_\_\_\_\_

Drivers License#: \_\_\_\_\_

Work Phone #: ( ) \_\_\_\_\_

Payment method:  Cash  Check

Credit Card – Enter card # above (if accepted)

\_\_\_\_\_ I hereby authorize assignment of my insurance rights and benefits  
Initials directly to the provider for services rendered. I fully understand I am  
solely responsible for any balance not paid by my insurance company (if offered at  
this office).

## 4

### IN EVENT OF EMERGENCY

Whom Should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_

Work Phone #: ( ) \_\_\_\_\_

Cell Phone #: ( ) \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

Medical Doctor's Phone #: \_\_\_\_\_

PLEASE CONTINUE ON BACK

**MEDICAL HISTORY**

PATIENT NAME: \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  YES  NO If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  YES  NO If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  YES  NO If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  YES  NO If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  YES  NO \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  YES  NO \_\_\_\_\_
- Are you on a special diet?  YES  NO \_\_\_\_\_
- Do you use tobacco?  YES  NO \_\_\_\_\_
- Do you use controlled substances?  YES  NO \_\_\_\_\_

Women: Are you:

Pregnant / Trying to get pregnant?  YES  NO Taking oral contraceptives  YES  NO Nursing?  YES  NO

Are you allergic to any of the following (check if yes)?

- Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs
- Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="radio"/> YES <input type="radio"/> NO | Cortisone Medicine        | <input type="radio"/> YES <input type="radio"/> NO | Hemophilia            | <input type="radio"/> YES <input type="radio"/> NO | Renal Dialysis             | <input type="radio"/> YES <input type="radio"/> NO |
| Alzheimer's Disease       | <input type="radio"/> YES <input type="radio"/> NO | Diabetes                  | <input type="radio"/> YES <input type="radio"/> NO | Hepatitis A           | <input type="radio"/> YES <input type="radio"/> NO | Rheumatic Fever            | <input type="radio"/> YES <input type="radio"/> NO |
| Anaphylaxis               | <input type="radio"/> YES <input type="radio"/> NO | Drug Addiction            | <input type="radio"/> YES <input type="radio"/> NO | Hepatitis B or C      | <input type="radio"/> YES <input type="radio"/> NO | Rheumatism                 | <input type="radio"/> YES <input type="radio"/> NO |
| Anemia                    | <input type="radio"/> YES <input type="radio"/> NO | Easily Winded             | <input type="radio"/> YES <input type="radio"/> NO | Herpes                | <input type="radio"/> YES <input type="radio"/> NO | Scarlet Fever              | <input type="radio"/> YES <input type="radio"/> NO |
| Angina                    | <input type="radio"/> YES <input type="radio"/> NO | Emphysema                 | <input type="radio"/> YES <input type="radio"/> NO | High Blood Pressure   | <input type="radio"/> YES <input type="radio"/> NO | Shingles                   | <input type="radio"/> YES <input type="radio"/> NO |
| Arthritis/Gout            | <input type="radio"/> YES <input type="radio"/> NO | Epilepsy or Seizures      | <input type="radio"/> YES <input type="radio"/> NO | Hives or Rash         | <input type="radio"/> YES <input type="radio"/> NO | Sickle Cell Disease        | <input type="radio"/> YES <input type="radio"/> NO |
| Artificial Heart Valve    | <input type="radio"/> YES <input type="radio"/> NO | Excessive Bleeding        | <input type="radio"/> YES <input type="radio"/> NO | Hypoglycemia          | <input type="radio"/> YES <input type="radio"/> NO | Sinus Trouble              | <input type="radio"/> YES <input type="radio"/> NO |
| Artificial Joint          | <input type="radio"/> YES <input type="radio"/> NO | Excessive Thirst          | <input type="radio"/> YES <input type="radio"/> NO | Irregular Heartbeat   | <input type="radio"/> YES <input type="radio"/> NO | Spina Bifida               | <input type="radio"/> YES <input type="radio"/> NO |
| Asthma                    | <input type="radio"/> YES <input type="radio"/> NO | Fainting Spells/Dizziness | <input type="radio"/> YES <input type="radio"/> NO | Kidney Problems       | <input type="radio"/> YES <input type="radio"/> NO | Stomach/intestinal Disease | <input type="radio"/> YES <input type="radio"/> NO |
| Blood Disease             | <input type="radio"/> YES <input type="radio"/> NO | Frequent Cough            | <input type="radio"/> YES <input type="radio"/> NO | Leukemia              | <input type="radio"/> YES <input type="radio"/> NO | Stroke                     | <input type="radio"/> YES <input type="radio"/> NO |
| Blood Transfusion         | <input type="radio"/> YES <input type="radio"/> NO | Frequent Diarrhea         | <input type="radio"/> YES <input type="radio"/> NO | Liver Disease         | <input type="radio"/> YES <input type="radio"/> NO | Swelling of Limbs          | <input type="radio"/> YES <input type="radio"/> NO |
| Breathing Problem         | <input type="radio"/> YES <input type="radio"/> NO | Frequent Headaches        | <input type="radio"/> YES <input type="radio"/> NO | Low Blood Pressure    | <input type="radio"/> YES <input type="radio"/> NO | Thyroid Disease            | <input type="radio"/> YES <input type="radio"/> NO |
| Bruise Easily             | <input type="radio"/> YES <input type="radio"/> NO | Genital Herpes            | <input type="radio"/> YES <input type="radio"/> NO | Lung Disease          | <input type="radio"/> YES <input type="radio"/> NO | Tonsillitis                | <input type="radio"/> YES <input type="radio"/> NO |
| Cancer                    | <input type="radio"/> YES <input type="radio"/> NO | Glaucoma                  | <input type="radio"/> YES <input type="radio"/> NO | Mitral Valve Prolapse | <input type="radio"/> YES <input type="radio"/> NO | Tuberculosis               | <input type="radio"/> YES <input type="radio"/> NO |
| Chemotherapy              | <input type="radio"/> YES <input type="radio"/> NO | Hay Fever                 | <input type="radio"/> YES <input type="radio"/> NO | Pain in Jaw Joints    | <input type="radio"/> YES <input type="radio"/> NO | Tumors or Growths          | <input type="radio"/> YES <input type="radio"/> NO |
| Chest Pains               | <input type="radio"/> YES <input type="radio"/> NO | Heart Attack/Failure      | <input type="radio"/> YES <input type="radio"/> NO | Parathyroid Disease   | <input type="radio"/> YES <input type="radio"/> NO | Ulcers                     | <input type="radio"/> YES <input type="radio"/> NO |
| Cold Sores/Fever Blisters | <input type="radio"/> YES <input type="radio"/> NO | Heart Murmur              | <input type="radio"/> YES <input type="radio"/> NO | Psychiatric Care      | <input type="radio"/> YES <input type="radio"/> NO | Venereal Disease           | <input type="radio"/> YES <input type="radio"/> NO |
| Congenital Heart Disorder | <input type="radio"/> YES <input type="radio"/> NO | Heart Pace Maker          | <input type="radio"/> YES <input type="radio"/> NO | Radiation Treatments  | <input type="radio"/> YES <input type="radio"/> NO | Yellow Jaundice            | <input type="radio"/> YES <input type="radio"/> NO |
| Convulsions               | <input type="radio"/> YES <input type="radio"/> NO | Heart Trouble/Disease     | <input type="radio"/> YES <input type="radio"/> NO | Recent Weight Loss    | <input type="radio"/> YES <input type="radio"/> NO |                            |  |

Have you ever had any serious illness not listed above?  YES  NO If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

## Consent/Authorization/Acknowledgement

### CLINICAL

I \_\_\_\_\_ authorize Cypress Mill Dental, referred to as "practice" hereafter, to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis. I authorize this practice to perform all recommended treatment and agreed upon treatment. I also authorize the use of anesthetics, sedatives and other medication (as needed) and am fully aware that using anesthetic agents involves certain risks.

### FINANCIAL

I am responsible for payment for services rendered on my behalf and my dependents. I have been informed that payment is due when services are rendered. **A \$50 Broken Appointment Fee** will be charged to my account for all broken and/or last minute cancellations. I am aware that to hold down operating costs, **24 Hours Notice** of cancellation is required.

### INSURANCE

I understand I am responsible for the deductible, co-payment and excess over maximum the day of service. Please keep in mind we file insurance as a courtesy and YOU are the responsible party, not you insurance company. The estimate of coverage shown is **NOT** a guarantee. We base all charges on information gathered by your insurance. I authorize this practice to submit claims for payment for services rendered r preauthorization necessary to my insurance company, on my behalf and in my name listed as "Signature on File" and assign to this practice the insurance benefits providing assignment is accepted. I understand that I am responsible for payment regardless of the coverage provided.

### HIPAA: Consent for Use and Disclosure of Health Information:

**Notice of Privacy Practices: You have the right to read this practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment payment activities, and healthcare operations, of the uses 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. Please read this Notice prior to signing this Consent. This practice reserves the right to change the privacy practices as described in our Notice of Privacy Practices. If changes are made, a revised Notice of Privacy Practices containing the modifications will be issued. These changes may apply to any of your protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices at any time.**

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Signature/Circle One: Adult Patient/ Parent / Guardian / Person Representative

Date

Please list the names of individuals you permit to disclose your protected health information.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please advise us of your preferred means of communication.

\_\_\_\_ You may/may not contact me at work.

\_\_\_\_ You may email me over an unsecured network.

\_\_\_\_ You may/may not contact me at home or leave a message.

Cypress Mill Dental

14315 Cypress Rosehill #150 Cypress, TX 77429 281-373-4533

### Written Financial Policy

Thank you for choosing Cypress Mill Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

#### **Payment Options:**

You can choose from:

-Visa, MasterCard, American Express or Discover Card –OR-

-NO INTEREST Payment Plans<sup>2</sup> from CareCredit

\*Allows you to pay over time with NO INTEREST<sup>1</sup>

\*Convenient, low monthly payment plans<sup>2</sup> also available

\*No annual fees or pre-payment penalties

#### **Please note:**

Cypress Mill Dental requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger more comprehensive treatment plans of \$2000 or more, a 25% deposit is required to secure your initial treatment appointment.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.<sup>3</sup>

A fee of \$50 is charged for patients who miss or cancel without 24 hour notice.

Cypress Mill Dental charges \$35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patients, Parent or Guardian Signature

Date

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Patient Name (Please Print)

<sup>1</sup>If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

<sup>2</sup>Subject to credit approval.

<sup>3</sup>However, if we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.