FOREST SQUARE

Dental

Patient Information

Patient Name: (Last) _____ (First) _____

Preferred Name: _____ Title: _____ Gender: M / F

DOB: ____/____/_____ Family Status: Married / Single / Child / Other

SSN#: _____-_____-_____Driver's License #: _____

Email: _____

Home Phone#: _____

Cell Phone #: _____

Can this cell phone number receive text messages? *Yes / No*

How do you prefer to be contacted about appointments?

Phone Call / Text Message

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Employer Phone #: _____

If patient is a minor:

Parent Name: _____ Employer: _____

Cell Phone #: _____ Work Phone #: _____

How did you hear about our office? _____

What is your reason for your visit with us today? _____

When is the last time you saw a dentist?_____

444 FOREST SQUARE STE.F • LONGVIEW, TX • 75605-4400 • P: 903.758.3722 • F: 903.331.0474 • FOREST.SQUARE.DENTAL.TX@GMAIL.COM

Multi-Provider Office Policy

Dr. Roberts and Dr. Jones strive for perfection in every aspect of the care we provide. We appreciate the trust our patients place in us and want to ensure that every patient is cared for like our own family. We have found great value in having multiple doctors available as individuals' schedules, needs or treatment complications arise.

As is the case in any healthcare practice, but especially dentistry, multiple views, opinions, and treatment options increase the likelihood of successful outcomes. We encourage each of our patients to get to know and be examined by both Dr. Roberts and Dr. Jones.

We have found great value in having both doctors alternate exams and treatment, yet we understand that this perspective may not always be shared by each of our patients. If there is any reason that you would prefer to be seen by just one provider, just let any member of our team know and we will make every effort to accommodate your request.

Insurance Information

Name of Primary Member on Insurance Plan: _____

DOB of Primary Member: ___ /___ / _____

SSN of Primary Member: _____-____-_____

Patient relationship to Primary Member: Self/Spouse/Dependent/Other

Primary Member's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Insurance Phone #: _____

Member ID: _____ Group Number: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Primary Member's Employer: _____ Phone #: _____

Do you have a secondary insurance policy? *Yes / No*

Dental Insurance Office Policy

If you have dental insurance you are responsible for bringing all of the information needed to file a dental claim. We must be able to verify insurance eligibility and benefits in order to accept your dental insurance.

Information given to you by our office regarding your benefits is a courtesy. We attempt to provide the most accurate information available, however, insurance companies will not release their fee schedules, so we cannot be held responsible for any discrepancies in benefits estimated.

We file insurance claims only as a courtesy to our patients and their families. You are responsible to pay the estimated difference between what your insurance plan covers and the actual charges incurred on the day of service. After insurance pays, you are responsible to pay for any balance in full upon notification by our office.

Signature: _____ Date: _____

Health History Information

Name of person completing form (if other than self): _____

Are you in good health? *Yes / No*

Have there been any changes to your health in the last year? *Yes / No*

If so, please describe: _____

Have you ever had IV sedation or general sedation? *Yes / No*

Were there any adverse effects? *Yes / No*

Do you generally tolerate dental treatment well? *Yes / No*

Have you had prosthetic joint replacement surgery? *Yes / No*

Please list all current medications: _____

_____

Would you or your spouse be interested in a non-surgical appliance to eliminate snoring? *Yes / No*

Do you have or have you ever had: (circle all that apply)

- Heart Disease that was detected at birth
- Rheumatic Fever or Rheumatic Heart Disease
- Chest Pain or Heart Trouble
- Heart Attack
- Heart Surgery
- Pacemaker
- Lung Disease (asthma, emphysema, bronchitis, pneumonia, TB, severe cough)
- Neurological Disorders
- Blood Disease
- Hepatitis
- HIV
- Kidney Disease
- Diabetes
- Thyroid Disease
- Arthritis
- Stomach Ulcers
- Frequent or reoccurring mouth sores
- Implants/Artificial Joints anywhere in your body
- Radiation in head or neck region
- Noises in jaw or joint pain near ear when chewing
- Sinus or nasal problems
- Any disease, drug or transplant operation that has depressed your immune system : _____

Are you taking/using any of the following: (circle all that apply)

- Antibiotics
- Anticoagulants/blood thinners
- Thyroid Medication
- Antihistamines or Decongestants
- High Blood Pressure or Heart Medication
- Steroids
- Tranquilizers or Antidepressants
- Stomach or GI medication
- Cholesterol reducing medication
- Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs
- Weight reduction pills or diet aids
- Vitamins or natural remedies

- Marijuana, cocaine or other recreational drugs

Are you allergic to or have had a bad reaction from: (circle all that apply)

- Local anesthetic
- Penicillin, Amoxicillin, Cephalosporin or other antibiotics
- Barbiturates or Sedatives
- Aspirin, Ibuprofen, NSAIDS or other pain medication
- Codeine, hydrocodone or other narcotics
- Latex
- Other: _____

Females are you: (circle all that apply)

- Taking birth control pills
- Pregnant, trying to become pregnant, or think you might be?
- Breastfeeding
- Taking hormonal replacement

Do you smoke? *Yes / No* If so, how much per day? _____

Do you drink alcohol? *Yes / No* If so, how much per day? _____

Do you use smokeless tobacco? *Yes / No* If so, how much per day? _____

Do you have any other disease, condition or problems not listed that you think the doctor should know about? _____

Disclosure Acknowledgement

I understand and agree that, regardless of my insurance coverage, I am ultimately responsible for the balance of my account for any professional services rendered and that payment is to be made in full at the time of my appointment. I understand that the insurance estimate provided to me is not a guarantee that my insurance will pay exactly as estimated. I authorize my insurance company to pay my dental benefits directly to my dental office. I have read all the information on this paperwork and I certify that the information I provided is true and correct to the best of my knowledge. I understand that providing incorrect information on my medical history can be dangerous to my health. I will notify you of any changes in my status or in the above information. This information will be kept confidential. I am responsible for updating this information if and when there are changes.

Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), that I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand Forest Square Dentals Notice of Privacy Practices. I understand that I may request in writing that Forest Square Dental restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Forest Square Dental is not required to agree to my requested restrictions, but if Forest Square Dental does agree than Forest Square Dental is bound to abide by such restrictions.

Signature: _____ Date: _____

Authority Granted to Treat

I hereby grant the authority for Scott C. Roberts, DDS and Nicholas Jones, DDS to administer such treatment and anesthetics as may be deemed necessary in the diagnosis and treatment of my case. I acknowledge that I have been informed of the risk of the procedure proposed and do authorize Dr. Roberts or Dr. Jones to proceed. Possible risks are paresthesia, numbness, excessive bleeding, allergy to medications, improper healing, dry sockets, damage to adjacent teeth, jaw fracture and sinus exposure leading to fistula.

Signature: _____ Date: _____