NEW PATIENT INFORMATION

Appointment Date: ______________

Thank you for choosing UNIDENT Family Dentistry.
Please fill out all the required information below and don't forget to provide your signature at the end!

PATIENT NAME: ______________________________ Driver License/ID:______________

* Male ☐ Female ☐ * DOB: ____ /____ /_______ * Age: ______ * Occupation: ____________________

Address: ______________________________ City: ______________ State _______ Zip: ______

Cell no. : ____________________ Alt. no.: ____________________ Email: ______________________________

LEGAL GUARDIAN/ PARENT (If patient is under 18):______________________________

Relationship to patient: Spouse ☐ Parent ☐ Other: ______________ Driver License/ID:___________

* Male ☐ Female ☐ * DOB: ____ /____ /_______ * Age: ______ * Occupation: ____________________

Address: ______________________________ City: ______________ State ______ Zip: ________

Cell no. : ____________________ Alt. no.: ____________________Email: ______________________________

HOW DID YOU HEAR ABOUT US? (Circle one)

Google	Flyers/ Mail	Another Patient:_______________
Facebook	TV/ Radio	Insurance Website:_______________
Sign –Drive by	Walk in	Other:____________________

EMERGENCY CONTACT PERSON

Name: ______________________________ Relationship:__________________

Cell no. : ____________________ Alt. no.: ____________________ Email: ______________________________

AUTHORIZATION TO RELEASE HEALTH INFORMATION (More details, please refer to Notice of Privacy Practices)

Please list the names of all people (e.g.: Spouse, Parents, Child, etc.) you authorize us to release your health information to (Including a copy of your records)

Name: ______________________________ Relationship: ________________ Phone #:________________

Name: ______________________________ Relationship: ________________ Phone #:________________

Name: ______________________________ Relationship: ________________ Phone #:________________

☐ Check here if you wish not to disclose your (or whom you represent) health information to anyone.

REASON(S) FOR TODAY' S VISIT: ______________________________

DON'T FORGET TO SIGN BELOW! ⇩

____
Signature of Patient, Guardian or Personal Representative

____
Date

UNIDENT Family Dentistry
3730 S. Gessner Rd. Suite #C-100. Houston TX 77063 | Office: 832-834-5544 | Fax: 832-834-5590

PLEASE FILL OUT FRONT & BACK

PATIENT MEDICAL HISTORY

GENERAL QUESTIONS
YES NO

- ☐ ☐ Have you ever had an experience in a DENTAL OFFICE that you would like to tell us about?
  If yes, please explain: ____
- ☐ ☐ Are you a current smoker?
- ☐ ☐ Are you nervous about dental treatment?
- ☐ ☐ Do you gums bleed, feel tender or irritated?
- ☐ ☐ Are your teeth sensitive? If Yes, to what? Sweet ☐ Cold ☐ Hot ☐ Pressure ☐
- ☐ ☐ Have you had your annual physical exam? If Yes, When? ____________________________
- ☐ ☐ Have you ever had any **excessive bleeding** requiring special treatment? If Yes, When? ________________
- ☐ ☐ Is there anything else we should know about your health?
  If yes, please explain: ____

PHARMACEUTICAL HISTORY (Please check any that apply):
Have you or are you currently taking any medications?

- ☐ Fosamax
- ☐ Actonel
- ☐ Aredia
- ☐ Boniva
- ☐ Jantoven
- ☐ Anticoagulants (blood thinner)
  If yes, please list: ______________
  ____
- ☐ High blood pressure medicine
  If yes, please list: ______________
- ☐ Antidepressants
- ☐ **Others medicine"**
  ____

Are you allergic or have you reacted adversely to any of the following?
(Please check any that apply):

- ☐ **Local Anesthetics**
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ **Penicillin**
- ☐ Sulfa Drugs
- ☐ Barbiturates or sedatives or sleeping pills
- ☐ Lodine
- ☐ Metals
- ☐ Acrylic
- ☐ **Latex**
- ☐ Other: ______________
- ☐ **NONE**

Do you have or have you had (Please check any that apply):

- ☐ Asthma
- ☐ Ulcers
- ☐ Stroke
- ☐ **High Blood Pressure**
- ☐ Heart Defect, Heart Murmur
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ Other Heart Problems: ______________
- ☐ Angina Pectoris
- ☐ Cancer/ Tumor
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Hives/Skin Rashes
- ☐ Herpes
- ☐ Mental Health Issues
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Fainting/Dizziness
- ☐ Steroid Treatment
- ☐ Angina Pectoris
- ☐ Eating Disorder
- ☐ Arthritis
- ☐ Persistent Cough
- ☐ Epilepsy/Seizures
- ☐ Rheumatic Fever
- ☐ Bone of joint problems
- ☐ HIV+, AIDS, ARC
- ☐ Hepatitis A, B, C
- ☐ High Cholesterol
- ☐ Diabetes TYPE 1 or TYPE 2
- ☐ Thyroids
- ☐ STD
- ☐ **NONE**

FOR FEMALES ONLY:

- ☐ *Are you or do you suspect to be pregnant?*
  If yes, when is the expected delivery date: ____________
- ☐ *Taking birth control pills*
  NOTE: *Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.*
- ☐ *Taking hormones or contraceptives*
- ☐ *I have irregular menstrual periods*

To best of my knowledge, all of the preceding answers are true and correct. If there is any change in my health and medicines. I will inform my dentist at the next appointment

______________________________ Signature of Patient, Guardian or Personal Representive

______________________________ Print Name

______________ Date

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INSURANCE AUTHORIZATION AND PAYMENT AGREEMENT

INSURANCE INFORMATION (Primary)

Name of Subscriber: ______________________________ Subscriber DOB ____ /____ /_____

Relationship to Patient: ______________________________

Subscriber ID #: ____________________ **SSN:** ________________ Group ID #: ________________

Insurance Company Name: ______________________________ Insurance Phone #: ________________

INSURANCE INFORMATION (Secondary)

Name of Subscriber: ______________________________ Subscriber DOB ____ /____ /_____

Relationship to Patient: ______________________________

Subscriber ID #: ____________________ **SSN:** ________________ Group ID #: ________________

Insurance Company Name: ______________________________ Insurance Phone #: ________________

☐ **CHECK THIS BOX IF YOU HAVE PROVIDED US YOUR INSURANCE INFORMATION.** You will not need to fill in this box again.

☐ **CHECK THIS BOX IF YOU HAVE NO INSURANCE.**

By signing this form, I certify that I, and/or my dependent(s) authorize my insurance company/Medicaid/CHIP to release all insurance information & benefits to **UNIDENT Family Dentistry**.

I accept all treatment that has been proposed and authorize any information that is necessary regarding this dental claim. I understand the policy of **UNIDENT Family Dentistry** regarding my insurance and my responsibility for the services that were rendered. I have read and understand my duties to accept my insurance for payment of my dental services. I understand that their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services

<u>I understand that I am responsible to pay in full for my balance if any of the following occur:</u>

A. The treatment that is proposed is more than my annual maximum.
B. My insurance denies any treatment.
C. I am not eligible for dental benefits.
D. I prevent or delay payment by not complying with the requirements of signatures on forms or any documents required by my insurance or doctor's office.
E. I do not finish my treatment and as a result my insurance does not pay for my treatment,
F. Lab fees that may accumulate for missing my appointments
G. I receive an insurance check for the services that were rendered and I did not forward it to the dental office.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to <u>inform</u> my doctor if I, or my minor child, ever have a change in health plans.

I hereby acknowledge that I received UNIDENT Family Dentistry's Notice of Privacy Practices. For more information regarding insurance coverage and payments, please review Financial Policy section under the Office policies page.

<u>DON'T FORGET TO SIGN BELOW!</u> ⇩

______________________________	________________	________________
Signature of Patient, Guardian or Personal Representive	Print Name	Date

***Payment is due <u>in full</u> at time of treatment unless prior arrangements have been approved**

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CONSENT FORMS

ELECTRONIC CHART PHOTO IDENTIFICATION CONSENT

UNIDENT Family Dentistry will be using electronic medical records to maintain your health care information and only using the below patient's photo for identification purpose. The use of electronic medical records allows us to store a digital photo of a patient in such patient's electronic chart so that our doctors and staff may visually identify such patient while reviewing her/his chart.

UNIDENT Family Dentistry is committed to maintain the confidentiality and privacy of all patient's health information in compliance with HIPAA rules and standards. Such photo will not be disclosed with any medical record releases and will not be shown to anyone other than UNIDENT Family Dentistry doctors and staff.

Please select the following:

☐ **YES** By checking "YES" and signing this consent, I am giving UNIDENT Family Dentistry permission to take a digital photo of me or my child to use and store in their electronic medical record system.

☐ **NO** I do not wish to have my or my child photo taken and stored in UNIDENT Family Dentistry's electronic medical records system for identification purpose.

DENTAL CLEANINGS, X-RAY AND PHOTOGRAPH CONSENTS

A. DENTAL CLEANINGS
It has been recommended by your general dentist at UNIDENT Family Dentistry that you receive a prophylaxis (Cleaning). Dental cleaning are essential for maintaining health in your mouth. Overtime, bacteria, food debris, and calcified (hardened) material can accumulate on your teeth that you toothbrush cannot remove. Some people get this accumulation much quicker and in greater amounts than others. It maybe recommend that you receive a professional cleaning every three (3), six (6), or twelve (12) months.

B. X-RAY AND PHOTOGRAPHS:
During an examination, X-ray(s) might be required or needed to diagnose patient's health condition. Dental photographs may also be needed to evaluate dental health.

FOR FEMALES ONLY:
I understand that if I am pregnant and have x-rays taken which expose my lower to radiation, it is possible to injure my fetus.
I have been advised that the ten (10) days following of a menstrual period are generally considered to be safe for x-ray exam. With those factors in mind, I believe I am not currently at risk. I wish to have x-ray exam performed today if presented by my doctor.

By signing this consent, the undersigned acknowledges that he/she has read the contents of this document, fully understands it, and agrees to be bound by it.

DON'T FORGET TO SIGN BELOW! ⇩

____
Patient Name

______________________________ ______________________________ ______________________________
Signature of Patient, Guardian or Personal Represenitive | Print Name | Date

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PLEASE FILL OUT FRONT & BACK

OFFICE POLICIES

❖ APPOINTMENT POLICY

We make every effort to see all patients on time and request that you extend the same courtesy to us. Appointment times are reserved exclusive for you and will be scheduled at time best suited for the treatment involved. Unannounced changes of appointments greatly affect other patients. Please inform our office 48 hours prior your appointment to make changes to void any fees.

❖ FINANCIAL POLICY

A. **Payment Options:** Payment(s) may be made by any of the following forms:
   - Cash
   - Credit Cards
   - Credit/Financing services with or without financial charges with Office Manager's approval

B. Payments:
Payment is due before any dental services is delivered to the patient. Treatment consisting of several visits will require an appropriate down payment or deposit on the first visit. Any changes incurred by this office related to collection of overdue accounts will be added to the patients account.

C. Insurance/Medicaid/CHIP Coverage:
Most insurance are accepted providing that verification of eligibility has been made prior to the appointment and that we can accept the assignment of benefits. Please know that our office will do everything possible to see that you receive the full benefits of you policy. However, we cannot guarantee any estimated coverage because the insurance policy is an agreement between you and the insurance company. UNIDENT Family Dentistry will file claims directly with your insurance/Medicaid/CHIP for services where covered benefits have been verified. A quote of benefits or eligibility is NEVER a guarantee of payment. Therefore, you are responsible for payment and any remaining balance that is not covered by the insurance. If your insurance has not paid your dental claim after 30 days of services rendered, it is patient's (your) responsibility to contact the insurance carrier and ask why they have not paid the claim.

D. Financial Estimates and Discounts:
Any Financial Estimates and Discount Offers will be expired after one (1) month from today's date (unless this has been arranged otherwise and approved by the Office Manager. E.g: promotions with restricted terms). Once the treatment is initiated, pricing & discounts will remain effected for 1 year or until the treatment is done. This may vary case by case.

E. Refund Policy:
There are no refunds for dental work that has been initiated (and paid) but not completed, or for any payments collected in advance but treatment not fully completed, regardless of any reason. Patients only receive a refund for any treatment that they did not receive, except when our policy for interrupted denture, crowns or bridge services applies; this includes lab-related procedures that have been initiated but not delivered or completed because of patient non-compliance or no show. Any credit on your account will be applied to future dental treatment.

- Third Party Lender Refunds: Any refunds of payment originated through third party lenders must be refunded to the original account. Please contact the third party lender for more information regarding their refund policy as processing or refunds may not be reflected on an account for up to two (2) billing cycles.

F. Access to Medical Records:
You have the right to look at or get copies of your health information, with limited exceptions. Please note that the office is required by law to maintain all original documents. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We are allowed by TSBDE to charge you a reasonable cost-s based fee for expenses such as copies and staff time. If you request photocopies, we will charge you $0.50 per page for the first 20 pages and $0.15 per page for every copy thereafter, as well as the cost of postage if you want the records mailed to you. Please also note that you duplicate X-rays are not available, then patient must come in to have another set of X-rays made in order for the office to maintain a copy on file. To request copies, please fill out the Medical Records Release form and submit to the office and allow 3-5 business days to process your request. The cost for copies of duplicate radiographs is as follows:

- A Full Mouth Radiograph Series, a Panoramic Radiograph, and a Lateral Cephalometric Radiograph: $15 each
- A Single Extra-Oral Radiograph, and a Single Intra-Oral Radiograph: $5 each

I hereby acknowledge that I have read UNIDENT Family Dentistry's Office Policies

______________________________ ______________________ ______________________

Signature of Patient, Guardian or Personal Representive | Print Name | Date

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PLEASE FILL OUT FRONT & BACK

Health Insurance Portability Act Acknowledgement Form (HIPAA)

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 **UNIDENT Family 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);
- Obtain payment from third party payers (e.g. my insurance company); and,
- The day-to-day healthcare operations of your practice.

I have also been informed of, and have been given the right to review and secure a copy of your Notice of Privacy Practices which contains a more completed description of the uses and disclosures of my protected health information, and my rights under HIPAA.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are 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.

I hereby acknowledge that I received UNIDENT Family Dentistry Notice of Privacy Practices and Office Policies.

DON'T FORGET TO SIGN BELOW! ⇩

______________________________	______________________	______________________
Signature of Patient, Guardian or Personal Represenitive	Print Name	Date

For Office Use Only

Patient/Legal Guardian or Personal Representative refuse to sign (Please check any that apply):

- ☐ NEW PATIENT INFORMATION
- ☐ AUTHORIZATION TO RELEASE HEALTH INFORMATION
- ☐ PATIENT MEDICAL HISTORY
- ☐ INSURANCE AUTHORIZATION AND PAYMENT AGREEMENT
- ☐ ELECTRONIC CHART PHOTO IDENTIFICATION CONSENT
- ☐ DENTAL CLEANINGS, X-RAY AND PHOTOGRAPH CONSENTS
- ☐ OFFICE POLICIES
- ☐ NOTICE OF PRIVACY PRACTICES
- ☐ Health Insurance Portability Act Acknowledgement Form (HIPAA)

Reason: ____

____

Patient/Legal Guardian or Personal Representative was unable to sign because:

- ☐ Communication Barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others:____

____

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