SOUTH PEEK
DENTAL CARE

6356 South Peek Rd, Ste. 700, Katy, TX 77450 | P: 832-712-2442 | www.southpeekdentalcare.com

WELCOME

Welcome to South Peek Dental Care! Our goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. Please fill out this form as completely as possible. We want to make sure that we are well informed about your medical history, current medications, and any other factors that might affect your dental health and treatment. The better we communicate, the better we are able to take great care of you.

General information

Today's Date _____

How did you hear about us?

- ☐ Facebook
- ☐ Google
- ☐ Website
- ☐ Email
- ☐ Mailer
- ☐ Walk in
- ☐ Word of Mouth:_____
- ☐ Other:_____

Name (First, Middle, Last): _____ Circle one: M F

Birthdate: _____ Age: _____ SSN#: _____

Address: _____ City: _____

State: _____ Zip:_____

Email: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Circle one: Single Married Widowed Divorced Separated Partnered Child

Emergency contact #: _____ Relationship: _____

Dental Insurance (please leave us your insurance card)

Insured's Name (If other than yourself): _____

Insured's DOB: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Probability & Accountability Act or 1996 ("HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will 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 physicians certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure's of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Date: _____

Office Use Only

I attempt to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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REQUEST FOR RELEASE OF HEALTH INFORMATION

I, _____ hereby grant permission to
(Print Name)

South Peek Dental Care to release information related to my health history, status, and treatment, and copies of my health record, x-rays, and any test results (Protected Health Information) to:

Name(s): _____

_____

Relationship to patient(s): _____

_____

Signature: _____ Date: _____
(If minor, parent or guardian must sign)

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MEDICAL HISTORY

Patient Name: _____ DOB: _____

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

Are you under a physician's care? ☐ Yes ☐ No If yes, _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, _____

_____

Have you every had a serious neck injury? ☐ Yes ☐ No

Do you take, or have taken, Phen-Fen or Redux? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel or any medications containing oral or

IV bisphosphonates? ☐ Yes ☐ No

Do you use any controlled substances? ☐ Yes ☐ No

Are you currently taking any blood thinners? ☐ Yes ☐ No

Are you taking any medications, pills or drugs? ☐ Yes ☐ No

List of medications: _____

_____

_____

Pharmacy name and phone: _____

Are you on a special diet? _____

Do you use tobacco? ☐ Yes ☐ No

Women: Are you pregnant/Trying to get pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Latex ☐ Penicillin ☐ Iodine ☐ Codeine ☐Milk products

☐ Barbiturates (sleeping pill) ☐ Local Anesthetic ☐ Sulfa Drugs ☐Nuts

☐ Acrylics ☐ Epinephrine ☐ Metal ☐ NSAIDS ☐ Other _____

If yes, please explain: _____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

Acid Reflux ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
AIDS/HIV Positive ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Sleep Apnea ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No	
Convulsions ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

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 _____

DENTAL HISTORY

Why have you come to our office today? _____ Are you in pain? ☐ Yes ☐ No If yes, for how long?

Last Visit Date: _____ Date of last cleaning: _____ Have you ever been told that you require antibiotics before dental treatment? ☐ Yes ☐ No

Do you have, or have you ever had any of the following conditions, ailments, or treatments? Circle "Yes" or "No."

Bad Breath ☐ Yes ☐ No	Broken Fillings ☐ Yes ☐ No	Clenching of Teeth ☐ Yes ☐ No
Food Collection Between Teeth ☐ Yes ☐ No	Gums Swollen or Tender ☐ Yes ☐ No	Lip or Cheek Biting ☐ Yes ☐ No
Orthodontic Treatment ☐ Yes ☐ No	Periodontal Treatment ☐ Yes ☐ No	Sensitivity to Sweets ☐ Yes ☐ No
Bleeding Gums ☐ Yes ☐ No	Burning Sensation on Tongue ☐ Yes ☐ No	Clicking or Popping of Jaw ☐ Yes ☐ No
Foreign Objects in Mouth ☐ Yes ☐ No	Jaw Pain ☐ Yes ☐ No	Loose Teeth ☐ Yes ☐ No
Pain Around Ear ☐ Yes ☐ No	Sensitivity to Cold ☐ Yes ☐ No	Sensitivity When Chewing ☐ Yes ☐ No
Blisters on Lips or in Mouth ☐ Yes ☐ No	Chew on Only One Side ☐ Yes ☐ No	Dry Mouth ☐ Yes ☐ No
Grinding Teeth ☐ Yes ☐ No	Jaw Fatigue ☐ Yes ☐ No	Mouth Breathing ☐ Yes ☐ No
Pain When Brushing ☐ Yes ☐ No	Sensitivity to Heat ☐ Yes ☐ No	Sores or Growths in Mouth ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No What else about your smile would you like to change? _____

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AUTHORIZATION & RELEASE

AUTHORIZATION, RELEASE & PAYMENT OPTIONS

- I authorize South Peek Dental Care to release any information including the diagnosis and the records of any treatment or examination rendered to my dependent or me during the period of such dental care to the third party mayors and/or other health practitioners.
- I authorize and request my insurance company to pay directly to South Peek Dental Care, insurance benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent(s).

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 60 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

Patient signature: _____ Date: _____

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FINANCIAL ARRANGEMENTS

ALL PATIENTS PLEASE READ THE FOLLOWING:
Payment for services is expected at the time service is provided.

CANCELLATION POLICY
At South Peek Dental Care we respect all of our patient's time. It is important to understand that the doctor or hygienists have reserved their time to be there for you. This time slot could have been given to someone who may desperately need his or her care. Therefore, please have the courtesy to give us 24 hours notice if you are unable to make your scheduled appointment.

IF YOU HAVE DENTAL INSURANCE
As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will **estimate** your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimate may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. You may find that our fees may be different from the insurance company's schedule of " allowable" or " UCR" fees. If you have any questions about " UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

Signature: _____

Date: _____

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PERMISSION TO TAKE PHOTOGRAPHS, SLIDES & VIDEOS

I, (Print Name) _____, hereby authorize South Peek Dental Care to take my photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, and professional publications.

_____ _____

Patient's Signature If a minor, signature of Parent or Guardian

_____

Date

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ACKNOWLEDGEMENT & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status. I understand that I will be required to pay my estimated portion of South Peek Dental Care's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.

Signature: _____

Print Name: _____

Date: _____