DRENNAN FAMILY DENTISTRY

2925 Oak Park Circle, Suite 100 • Fort Worth, TX 76109 • 817-732-5522

PATIENT INFORMATION: ***Please fill out all below information***

Name: ____ Date: ______________

Address: ____

City: ____________________________________ State: _________________ Zip Code: _____________________________

Home #:________________________ Work #:__________________________ Cell #:_________________________

Birth date: ______________________ Sex: ________________ Please circle one: Single Married Divorced

Social Security #_______________________________ Driver's License #: ___________________________

Spouse's Name: _______________________________ Spouse's birth date: _________________________

Email: ____

Whom may we thank for referring you to our office? ____

HEALTH INFORMATION: ***Please update this information if there are any changes***

1. Circle if you have ever had any of the following:

Alcohol/Drug Abuse	Diabetes (HbA1c ______)	High Cholesterol	Radiation Therapy
Alzheimer's/Dementia	Difficulty Breathing	History - Infective Endocarditis	Respiratory Problems
Anemia	Dizziness	HIV/AIDS	Rheumatism
Anxiety/Depression	Emphysema	Human Papilloma Virus	Seasonal Allergies
Arthritis	Epilepsy	Joint Replacement	Seizures
Aspirin Daily	Fainting	Kidney Problems	Shingles
Asthma	Gastric Reflux	Liver Problems/Jaundice	Sinus Problems
Autoimmune Disease	Headaches/Migraines	Low Blood Pressure	Sleep Problems/CPAP use
Bad Breath	Heart Attack	Mitral Valve Prolapse	Stroke
Bisphosphonate Therapy	Heart Murmur	Pacemaker	Thyroid Disease
Bleeding Problems	Heart Surgery/Bypass	Parkinson's	TMJ/Clenching/Grinding
Blood Transfusion	Hepatitis	Pregnant- Currently	Tobacco Use
Cancer/Chemotherapy	Herpes/Fever Blisters	Prolonged bleeding (INR>3.5)	Tuberculosis
Congenital Heart Defect	High Blood Pressure	Prosth/Artificial Heart Valve	Ulcers

2. Please list any other serious medical conditions that you had which are not listed above: _________________________
____

3. Are you allergic to any of the following: *(please circle all that apply)*

Aspirin/Ibuprofen	Jewelry	Sulfa Drugs
Codeine	Latex Rubber	Tetracycline
Dental Anesthetics	Metals	Tylenol
Epinephrine	Penicillin	Keflex
Erythromycin		

4. Please list any medications you are taking: ____
____

5. Have you been hospitalized in the past 2 years? ____

6. Please list any other drugs/medication that you are allergic to: ____

7. Do you need antibiotic premedication before dental appointment: YES NO

8. Last Dental Visit: _______________ Chief Complaint/Pain: ____

What do you like/dislike about your smile? ____

9. Physician____ Phone #____

Signature: ____ Date: ______________________________________

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Welcome to our practice,

From the moment you walk through our door you will notice that our goal is to make you feel at home in our pleasant, relaxed atmosphere. Our friendly staff will take special care to make certain that you are comfortable and well cared for. We provide advanced dental care, and have dedicated our practice to excellence in painless dentistry. Your dental health is of the utmost importance to us. To this end we will educate and counsel you on all procedures that you may require. Our staff is prepared to help train patients in preventive dental care and proper hygiene. We look forward to a long term professional relationship with people such as you; to this end we have prepared the following so that you know what is expected of you, and we welcome you to our practice.

Payment Responsibilities:

Payment for services is *due at the time of services are rendered*. For you convenience we accept MasterCard, Visa, Discover, and American Express. Returned checks and balances older than 30 days will be subject to additional collection fees and interest charges of 1.5% of the total balance per month. Charges may also be assessed for repeated missed appointments without a 24 hour advance notice.

Insurance Policy:

All co-pays are due at the time of service and we will file with your insurance company. Co-payments are calculated based on information we receive from your insurance company. You must realize however that your insurance is a contract between you, your employer, and the insurance company. We are not party to the contract. Our fees are generally considered within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. Not all services, however, are a covered benefit in all contracts. We must emphasize that as dental care providers our relationship is with you-not your insurance company. All charges are your responsibility from the date the services are rendered.

DENTAL INSURANCE INFORMATION: ***Please update this information if there are any changes***

Insured Name: ____________________________________ Insured Date of Birth: ______________________________

Employer: ____ Relationship to Insured: _____________________________

Insurance Company: _______________________________ Phone #: ____

Group#: ____ Insurance Address: _________________________________

Policy #: ____ City, State, Zip: ___________________________________

I have read and fully understand the above financial policy.

Signature____ Date____________________________

ACKNOWLEDGE OF PRIVACY PRACTICES-HIPAA

The Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide & coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers for my health services. Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices contain a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

At times we will need to contact you concerning information that is specific to you, your treatment and your dental needs. Information that is requested to be sent to you, or on your behalf, by our office via email will be sent in standard email format. We do not have encrypted services available for such communication. We may have the need to use the telephone for confirmation of appointments or verification of health/dental needs. We will remain mindful all HIPAA laws concerning release of information in these instances.

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 health care operations and I understand that 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's Printed Name

____

Patient/Guardian's Signature Date

Please list below anyone who the patient allows to receive about their dental needs.

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