TRUTH

PATIENT INFORMATION

First Name:____________________ Last Name: ___________________ MI: ____ Preferred Name: ___________________

Birthdate: _____________________ SS#: ________________________ Gender: Male/Female Married: Yes/No

Work Phone: ____________________ Home Phone:_____________________ Cell Phone: __________________________

Emergency Contact:___________________________ Phone:____________________ Relationship:___________________

Email: ____

Preferred contact method: Work Home Cell Email

Address: ____

City: ____________________________ State: _______ Zip Code: ________________

YOUR TRUTH

We want to get to know you better! Tell us about your hobbies or interests.

____

REFERRAL INFORMATION

Can we thank someone for referring you or did you find us on your own? Please, let us know how you find us.

____

INSURANCE

Relationship to subscriber: Self Spouse Child

Subscriber's Name: ___________________________________ Subscriber ID#: ____________________________________

Insurance Carrier: ____________________________________ Phone: ____

Employer: ____ Group #: ____

HEALTH QUESTIONAIRE

Please answer by circling yes or no by each individual question.

Are you in good health?____ Y N

Any changes in your general health in the past year?____ Y N

Last check up date by primary physician?____ Y N

Are you currently under a physician's care?____ Y N

If so, what for?____

Treating Physician Name: ____________________ Phone Number: ____________________

Have you ever had any serious illness, major operations, or hospitalized? ____________________ Y N

If so, describe and give approximate dates: ____

____

Do you have or ever had the following medical conditions:

Heart Disease that was detected at birth? ____ Y N

Rheumatic fever of Rheumatic heart disease? ____ Y N

Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitation, heart surgery, angioplasty, pacemaker)? ____________________ Y N

Lung disease(asthma, emphysema, chronic cough , bronchitis, pneumonia, TB, shortness of breath, severe cough)?____ Y N

Neurological Disorders (seizures, epilepsy, fainting, dizziness, nervous disorder)? ____________________ Y N

Blood disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? ____________________ Y N

Liver disease?____ Y N

Kidney disease? ____ Y N

Diabetes? ____ Y N

Thyroid disease? ____ Y N

Arthritis? ____ Y N

HIV/AID'S?____ Y N

Stomach ulcers or Intestinal problems? ____ Y N

Glaucoma?____ Y N

Frequent or recurring mouth sores?____ Y N

Implant/Artificial joints anywhere in your body? (heart valve, hip, knee)?____________________ Y N

Radiation (X-ray treatment for cancer) in head or neck region?____________________ Y N

Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth?____________________ Y N

Sinus or nasal problems? ____ Y N

Any disease, drug or transplant operation that has depressed your immune system? ____________________ Y N

Have you ever been hospitalized or had major operations? ____________________ Y N

HEALTH QUESTIONAIRE

Please answer by circling yes or no by each individual question.

Recurrent infections of any kind? ____________________ Y N

Do you snore? ____________________ Y N

Do you generally tolerate dental treatment well? ____________________ Y N

Do you use spit tobacco? ____________________ Y N

If so, what kind and how much? ____________________

Do you have any other diseases, conditions or problems not listed above that you think the doctor should know? ____________________ Y N

Are you allergic to any of the following:

Local anesthetic (Novocain-like drugs)? ____________________ Y N

Penicillin, Amoxicillin, Cephalosporins? ____________________ Y N

Other antibiotics? ____________________ Y N

Barbiturates, sedatives? ____________________ Y N

Aspirin, Ibuprofen, NSAIDS, or other pain medicine? ____________________ Y N

Codeine or other narcotics or opioids?____________________ Y N

Latex? ____________________ Y N

Other allergies or reactions? ____________________ Y N

Are you taking any of the following:

Antibiotics? ____________________ Y N

Anticoagulants(blood thinners)? ____________________ Y N

Thyroid medications? ____________________ Y N

Antihistamines, decongestants? ____________________ Y N

High blood pressure or Heart medications? ____________________ Y N

Steroids? ____________________ Y N

Tranquilizers, antidepressants ? ____________________ Y N

Stomach or G.I. medications (antacids, etc.)?____________________ Y N

Cholesterol reducing drugs? ____________________ Y N

Aspirin, Ibuprofen, NSAIDS, or anti-inflammatory drugs, narcotics, opioids, or other pain relievers)?_______ Y N

Weigh reduction pills? ____________________ Y N

Vitamins or natural remedies? ____________________ Y N

HEALTH QUESTIONAIRE

Please answer by circling yes or no by each individual question.

Women

Are you taking oral contraceptives?

If so, please list the name.

Are you pregnant, trying to become pregnant, or is there a chance you may be pregnant?

Are you nursing?

New Patients

If you could change your smile, what would you do? ____________________________

Why did you leave your previous dentist? __________________________________

Date of last dental visit? ____

Reason for today's visit?____

Are you in pain? YES/NO

I __________________________________, understand the importance of a **TRUTHful** health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate**.**

Patient Signature ____ Date_______________

Doctor Signature ____ Date_______________

TRUTH

APPOINTMENT POLICY

Standard Policy

We kindly ask that you give us a minimum of 24 hours notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments. Patients who provide less than 24 hours notice, or miss their appointment, may be charged a cancellation fee.

Evening Appointments

Your evening appointment time is reserved just for **YOU**. To secure your appointment we require a valid credit card number to hold your appointment. Your credit card number will be stored in our secure credit card vault. You may call into our office (713-814-5986) to give us your credit card number, or our office manager/scheduling coordinator will call you to obtain it. Your appointment is not fully booked in our system until we have a credit card on file. Your credit card **will not be charged** until a day prior to your appointment.

Evening appointment times are limited. Therefore, *we require 48 hours notice* for any cancellations or changes to your evening appointments. Patients who provide less than 48 hours notice, or miss their appointment, may be charged a cancellation fee of **$50**.

Signature: ____ Date: ____

TRUTH

NOTICE OF PRIVACY

In the event , that you may want a family member or friend to discuss your treatment with our office, we must have consent/permission in writing from you to do so.
Please list any person you give Truth Dentistry consent/permission to discuss your information such as account information, x-ray's, treatment, etc.

I ______________________________, herby give consent/permission to Truth Dentistry to discuss any and all dental information with the name individuals below:

Name: ________________________________ Date of birth: _________________________

Name: ________________________________ Date of birth: _________________________

I ________________________________, do not wish for Truth Dentistry to discuss any of my dental treatment with anyone other than me.

Signature: ____ Date: ____________________________________

TRUTH

CONSENT FOR SERVICES AND FINANCIAL POLICY

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

GENERAL

Thank you for choosing our practice as your Primary Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, ICARE, and HEALTH FLEX CARDS.

DENTAL INSURANCE

Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ESTIMATED co-payment on the day services are rendered. We will gladly file your insurance claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. After a statement's of accounts have been sent and a balance is left on the account after 60 days, patient will be informed that balance will now be sent to our collections department.

INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All ESTIMATED portions and deductibles are due prior to treatment. In the event YOUR insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising the office if you have a change in your insurance coverage prior to your appointment.

USUAL AND CUSTOMARY RATES

Truth Dentistry is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa/MasterCard, American Express, Discover, Icare, Health Flex Card or payment by cash or check at time of service has been verified.

Signature: ____________________________________ Date: ____

TRUTH

ASSIGNMENT OF BENEFITS

I____ hereby assign, convey and transfer all dental benefits directly to which I am entitled to Truth Dentistry. I hereby authorize and direct all my insurance carrier(s), including Medicaid, Private insurance and any other health/medical plan , to issue payment directly to Truth Dentistry. This assignment includes the right to purse all associated administrative remedies, claims and/or lawsuits against such policies and/or plans including and expressing/knowing assignment of ERISA, breach of fiduciary duty claims and any other administrative claims.

I____, authorize Truth Dentistry to initiate a complaint with the Texas Department of Insurance and or Insurance Commissioner on my behalf.
I understand that I am financially responsible to Truth for any and all charges regardless of any applicable insurance of health care benefits, and any payment received from these policies and/or plans will be applied to the amount I have agreed to pay for the services rendered. It is my responsibility to notify Truth Dentistry of any changes to my health care coverage. I understand by signing this form I am accepting financial responsibility fro payment for all products and services received by Truth Dentistry.

In certain circumstances, insurance companies may send a check for services provided by Truth Dentistry directly to the patient. In such cases, the patient agrees to endorse and send such check to Truth Dentistry within 10 days of receipt of the check.

I hereby authorize Truth Dentistry to: (1) release any information necessary to insurance carriers, adjusters, or attorneys regarding my diagnosis and treatment; (2) process insurance claims generated in the course of examination and treatment; (3) and allow a photocopy of my signature and this form to be used to process insurance claims. The authorization will remain in effect until revoked by me in writing.

I ____, have request dental services from truth Dentistry on behalf of myself and/or my dependents and understand by making this request that I am fully financially responsible for any and all charges incurred in the course of treatment authorized.

Signature: ________________________________ Date: ____________________________________