Preston Dental Center

Patient Information

Patient Name: ____ Preferred Name: ____________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other______________

Social Security #: ______________________ Birth Date:______________________

Phone (Home): ____________(Work):____________ Ext:______ Pager/Cell: ____________

E-Mail Address:______________________________ We occasionally send out an e-newsletter with announcements or news about our practice. Please check here if you do NOT wish to receive these ____

Home Address:____
Street Apartment #

____
City State Zip Code

Employer Name: ________________Position:______________How long there?:__________

Please list other members of your immediate family who are patients in our office______________________

Referral Information

Can we thank someone for referring you?

Family member ____________________

Coworker ____________________

Friend ____________________

Doctor ____________________

Or did you find us on your own?

___ Our award winning website.
(How did you find it?) ______________
___ Cosmetic Dentist Finder
___ Yellow Pages
___ WFAA's Dental Health Check
___ Location
___ Newsletter
Other ____________________

Date of Last Dental Visit: ____________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Anemia
☐ Asthma
☐ Chemical Dependencies
☐ Diabetes
☐ Epilepsy
☐ Heart Disease
☐ Heart Murmur

☐ Hepatitis
☐ High Blood Pressure
☐ Joint Replacement
☐ Pacemaker
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Tuberculosis
☐ Transplant/Prostheses

☐ Allergic to Nickel? ______
Recent Surgeries?________
Are you currently pregnant? ☐ Yes ☐ No
If so, due date:________

Do you prefer Nitrous Oxide (laughing gas) during dental procedures?
☐ Yes ☐ No
Drug Allergies:
____
____

- Do you currently use tobacco? ☐ Yes ☐ No If so, how long? ________ Do you want to quit? __________
- Have you ever had any complications or allergic reactions following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- Name of primary Physician: ______________________ Phone:______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____
- Medications you are taking:____
- Why did you leave your previous dentist? ______________________________________
- Are you interested in sedation dentistry? ☐ Yes ☐ No

- Are you interested in whitening your teeth? ☐ Yes ☐ No • Do you have concerns about snoring? ☐ Yes ☐ No
- If you could change your smile, what would you do?____
- Do you ever have a bad taste in your mouth? ____

Do you prefer to see a particular doctor or hygienist in our practice? ________________________

We routinely use latex products for your safety. If you have a known sensitivity to latex products, please notify us prior to being called back to the treatment room.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date:______________

Signature of patient, parent or guardian

Insurance Information

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ Social Security #: __________________ Group #:__________

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other________________

Dental insurance company name: ______________________________________

*Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

____ Date:______________
Signature of patient, parent or guardian

Consent for Services

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.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability but the patient agrees that this is an estimate only, not a guarantee of coverage.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I agree to have any photos taken of me to be used for education and training.

I have read the above conditions of treatment and payment and agree to their content.

________________________________ Date: ____________ Relationship to Patient: ________________
Signature of patient, parent or guardian