Brazos Family Dentistry
Confidential Patient Information if patient is an ADULT

Please print

Date_____

Adult Patient's Name
(First)_____ (Last)_____ (MI)_____
By what name do you prefer to be called?_____

Age_____ Date of Birth_____ Sex_____ Marital Status_____
Home phone_____ Cell phone_____
Email_____
Address_____ City, State_____ Zip_____

Employer_____ Occupation_____ Business phone_____
Employer address_____ City, State_____ Zip_____
SS#_____ DL#_____

Spouse's Name_____ Date of Birth_____
Employer_____ Occupation_____ Business phone_____
Employer address_____ City, State_____ Zip_____
SS#_____ Cell phone_____

Insurance Information

Insured Name_____ Date of Birth of Insured_____
Insurance Co. Name_____ Group #_____
Insurance Co. Ph #_____ Insured ID or SS #_____

We will gladly process your forms if you provide us with your insurance information. This allows you to pay your ***estimated*** portion when services are rendered, rather than paying us in full. Necessary forms should be completed and signed by patient and/or insured to expedite insurance carrier payments. ***If payments are mailed to the patient, payment is requested in full at the time services are rendered unless arrangements have been made.***

Acknowledgement and Authority

All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services as they are rendered. Fees change without notice. Pre-estimated fees are good for up to 6 months if treatment does not change. There will be a $25.00 charge for all returned checks. Should this account become delinquent, I understand that I am responsible for all legal fees, court costs, and collection charges involved as a result of any collection activity

Patient signature_____ Date_____

Patient Health History

Physician's Name_____ Office #_____ Fax #_____
Pharmacy #_____

Please indicate any illnesses or medication you have with a YES or NO.
Detailed information regarding your health is important for your dental team to be aware of. Thank you.

Cancer	____	Chemotherapy	____
Rheumatic Fever	____	Fainting Tendency	____
Heart Conditions	____	Blood Thinners/Anticoagulants/Daily Aspirin	____
Abnormal Blood Pressure	____	Sedatives	____
Chest Pain	____	Cortisone Drugs (Anti-inflammatory)	____
Shortness of Breath	____	Epilepsy	____
Asthma or Hay Fever	____	HIV Positive	____
Sinus Trouble	____	Tuberculosis	____
Kidney or Bladder Trouble	____	Diabetes	____
Hepatitis or Jaundice	____	Prolonged Bleeding	____
Severe Headaches	____	Smoke or smokeless tobacco use (circle which one above)	____

Last dental visit_____

Any undesirable effects from any anesthetics? If so, tell us what happened._____
_____

For females only:
Are you taking birth control pills?_____ Are you pregnant?_____
Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

Have you had any operations? If so, please list them._____
Are you or have you ***ever*** taken Bisphosphonates like Fosamax or Boniva for osteoporosis?_____
Are you taking any medications either by prescription or over the counter? If yes, list them here.
_____
Are you allergic to penicillin?_____ If yes, what kind of reaction?_____
Are you sensitive or allergic to any other medicines? If yes, list them here._____

Emergency Notification
Name of person you would like notified in case of emergency_____
Emergency contact's cell phone_____ Work phone_____
Who may we thank for referring you to our office?_____

Patient signature_____ Doctor signature_____

Brazos Family Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement. However, this will render the filing of your insurance claims your responsibility as well as prevent our office from calling any prescriptions that you may need into your pharmacy.

I, _____, have received a copy of this office's Notice of Privacy Practices or have seen it visibly posted in the office reception area. This release of information is valid while the person above is a patient in this office.

_____
Please Print Name

_____
Signature

_____
Date

_____
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please specify below)

_____
_____

Brazos Family Dentistry
Financial Policy

Thank you for choosing Brazos Family Dentistry to provide your dental care. We are committed to providing you the best possible dental care. In order to prevent any misunderstandings and to serve you better, we ask that all patients/guarantors read and understand our financial policy. We will gladly answer any questions you may have about services provided, fees, financial policy, or any other aspect of your care.

1. Payment is due at the time services are rendered
   - -Forms of payment: cash, most credit cards, and checks with a valid Tx Driver's License.
   - -Inability to make payment at that time may require your appointment to be rescheduled.
   - -Deductibles, co-insurance, and non-covered services must be paid at the time of service.

2. Insurance acceptance and filing
   - -As a courtesy, we will file insurance for you.
   - -Changes in insurance should be provided prior to your visit. Present your new insurance card so we can verify your coverage.
   - -If you do not inform us of an insurance change, and we have not been able to collect from your previous insurance, you will be responsible for any unpaid balances.
   - -Any amount due after insurance pays is your responsibility and due upon notification regardless of any clauses or waiting periods that you may have.

3. Returned checks
   - -Returned checks will incur a $25.00 fee. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card to prevent further action.
   - -Once there is a returned check, we will no longer accept personal checks.

4. Accounts turned over to a collection agency
   - -Accounts with unpaid balances with no payment activity for 90 days may be turned over to a collection agency.
   - -If this happens, a collection fee of 35-50% of the balance will be added to your account balance.
   - -We understand that temporary financial problems may affect timely payment, so we encourage communication of such problems to us at 281-342-0163 so that your account can be properly managed.

5. Changes in Personal Information
   - -Changes in address or telephone numbers should be kept current with our office. If we are unable to contact you regarding an overdue balance, your account will be turned over to a collection agency.

6. Missed appointments
   - -Please let us know 24 hours in advance if you cannot keep your appointment.

We are happy to help you maximize the allowable benefits with your dental insurance plan. It is, however, your responsibility to know and understand your own insurance benefits, coverage, pre-existing condition clauses, and waiting periods. We will assist you in any way we can with this. We look forward to helping you achieve a healthy and beautiful smile.

I have read and understand the above financial policy.

_____	_____	_____
Printed Name	Signature	Date

Brazos Family Dentistry
Credit Card Authorization and Consent Form

I authorize Dr. Monique Vu to keep my signature on file and to charge my Mastercard, Visa, or Discover account as indicated below:

Check one: [ ] Mastercard [ ] Visa [ ] Discover [ ] Care Credit

Balances on my account not paid by insurance within 90 days from the date of service will be charged to my credit card.

I assign my insurance benefits to the provider listed above. I understand that this form is valid unless I cancel this authorization through notice to the healthcare provider.

If patient receives dental payment from the insurance company, it is the patient's responsibility to either forward the check to the dental office or write a personal check for the amount of the insurance payment. Failure to do so may result in legal fees, court costs, and collection charges involved as a result of collection activity.

_____
Patient Name

_____
Cardholder Name

_____
Cardholder Billing Address

_____
City State Zip

_____ _____
16 Digit Account Number 3 Digit Security Code on Back of Card

Exp: Month_____ Year_____

_____ _____
Cardholder Signature Date