The Art of Dentistry

Van E. Parham, Jr., D.D.S., F.A.G.D.

Family, Cosmetic and Orthodontic Dentistry
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(972) 255-9000

PATIENT INFORMATION

Patient Legal Name_________________________________ Preferred Name____________________________

Address____Apt#_________

City ____ State________________ Zip___________________

Home Phone_____________________________________ Work Phone____________________ Ext. _______

Cell Phone_________________________________ Driver's License #____________________________

Birth Date_______________________ Social Security #______________________________

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

E-mail Address ____

Patient Employed By ____ Occupation______________________

Whom May We Thank for Referring You? ____

Person to Contact in Case of Emergency _____________________________Phone_______________________

In order to serve you better, please answer the following questions:

Do you prefer an AM or PM appoint? (Circle one) AM PM No Preference

What is the best way to contact you to confirm appointments: ______________________________

If Patient is minor/child:

Parent/Guardian Name _________________________________Social Security #_______________________

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Birth Date______ Driver's License #____________ Cell phone____________________________

Parent/Guardian Employed By ___________________________Work Phone__________________________

If patient is a full-time student, Name of School/College _________________City______________________

Dental Insurance or "Dental Assistance," as it should be called, is designed to help pay "part" of the cost of dental treatment. Your employer has made this coverage available to you and we will do our best to help you maximize its benefits.

Dental Insurance is NOT designed to pay all the cost of treatment, but rather to be a PARTIAL AID.

Your insurance contract is BETWEEN YOU AND YOUR INSURANCE COMPANY. The types of benefits in your coverage depend on what your employer has negotiated with his company and the amount of money you wish to pay in premiums.

If your insurance company has not paid the estimated portion within 45 days, the balance becomes YOUR RESPONSIBILITY. We file the insurance as a COURTESY to ALL of our patients, in hopes to aid our patients of the stress of insurance.

____ ___________________________
Signature of Patient or Responsible Party Date

Medical History

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

Describe or List			
Are you under a physician's care now?	☐Yes	☐No	________________________
Have you ever been hospitalized or had a major operation?	☐Yes	☐No	______________________
Have you ever had a serious head or neck injury?	☐Yes	☐No	______________________
Are you taking any medications, pills, or drugs?	☐Yes	☐No	______________________
Do you take, or have you taken, Phen-Fen or Redux?	☐Yes	☐No	______________________
Are you on a special diet?	☐Yes	☐No	______________________
Do you use tobacco?	☐Yes	☐No	______________________
Do you use controlled substances?	☐Yes	☐No	______________________
Have you ever had BOTOX or DERMAL FILLERS	☐Yes	☐No	______________________

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?
☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other____________

Check if you have or have had any of the following:

☐AIDS/HIV Positive	☐Chest Pains	☐Frequent Headaches	☐Irregular Heartbeat	☐Scarlet Fever
☐Alzheimer's Disease	☐ColdSores/FeverBlisters	☐Genital Herpes	☐Kidney Problems	☐Shingles
☐Anaphylaxis	☐CongenitalHeartDisorder	☐Glaucoma	☐Leukemia	☐Sickle Cell Disease
☐Anemia	☐Convulsions	☐Hay Fever	☐Liver Disease	☐Sinus Trouble
☐Angina	☐Cortisone Medicine	☐Heart Attack/Failure	☐Low Blood Pressure	☐Spina Bifida
☐Arthritis/Gout	☐Diabetes	☐Heart Murmur*	☐Lung Disease	☐Stomach/Intestinal Disease
☐Artificial heart Valve*	☐Drug Addiction	☐Heart Pace Maker*	☐Mitral Valve Prolapse*	☐Stroke
☐Artificial Joint*	☐Easily Winded	☐Heart Trouble/Disease	☐Pain in Jaw Joints	☐Swelling of Limbs
☐Asthma	☐Emphysema	☐Hemophilia	☐Parathyroid Disease	☐Thyroid Disease
☐Blood Disease	☐Epilepsy or Seizures	☐Hepatitis A	☐Psychiatric Care	☐Tonsillitis
☐Blood Transfusion	☐Excessive Bleeding	☐Hepatitis B or C	☐Radiation Treatments	☐Tuberculosis
☐Breathing Problem	☐Excessive Thirst	☐Herpes	☐Recent weight Loss	☐Tumors or Growths
☐Bruise Easily	☐Fainting Spells/Dizziness	☐High Blood Pressure	☐Renal Dialysis	☐Ulcers
☐Cancer	☐Frequent Cough	☐Hives or Rash	☐Rheumatic Fever*	☐Venereal Disease
☐Chemotherapy	☐Frequent Diarrhea	☐Hypoglycemia	☐Rheumatism	☐Yellow Jaundice

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

We only need the following information if we need to request x-rays or information:

Former Dentist____
Address and/or phone number____

Date of last dental care______________________________Date of last dental X-rays________________

In case of Medical Emergency:
Physician's Name__________________________________Date of last visit_________________________

I Certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

____ ___________________________
Signature of Patient or responsible Party Date

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Our Financial Alliance

We at Dr. Parham's office are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive health care as cost-effective as possible. Please understand that payment of your bill is considered a part of your treatment.

YOUR ESTIMATED SHARE OF THE CHARGES ARE DUE AT THE TIME OF SERVICE.

- WE ACCEPT CASH, CHECKS, MONEY ORDERS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.
- CARE CREDIT- FINANCING PLAN WE OFFER AS A SEPARATE LINE OF CREDIT WHICH OFFERS FLEXIBLE FINANCING OPTIONS WITH APPROVED CARE CREDIT. UP TO 12 MONTHS NO-INTEREST. (We would be more than happy to give you the application)

Please initial the following:

______ I understand dentistry is not an exact science and no specific results can be assured or guaranteed. I understand treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated laboratory fees are my financial responsibility.

__________ We understand how valuable your time is and we will do everything possible to keep on track and make sure you are seen in a timely manner. When we make an appointment we reserve time in our schedule just for you, and we ask that you do the same for us. Unless cancelled, at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Lets both try and mark time for each other when we are less likely to run into problems – meetings, birthdays, vacations, etc… Please help us serve you better by keeping scheduled appointments.

________ HIPPA – As required by the Privacy Regulations, by signing below, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES". I also understand that this office may change their Notice of Privacy Practices and is not required to honor the terms of the original/previous version(s).

Please let us know if you have any questions or concerns before signing this agreement.
I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I agree that parents are responsible for all fees and services rendered for treatment of a minor/child. To the extent permitted under applicable law, I authorize release of any information relating to my dental services. I hereby authorize payment of the dental benefits to the treating dentist or dental practice. I understand that in the unlikely situation that my account was turned over for collections or litigation – I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 18% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collections efforts. I have read and understand this Financial Protocol.

______________________________________ ______________________
Signature of Patient or Responsible Party Date

Dental Health Information

Thank you for providing us with Important Information that will help us serve you better.

Are you having any discomfort? Yes No

Any sensitivity to hot, colds, sweets, chewing? Yes No

Does dental treatment make you nervous? Yes No

Have you experienced any of the following problems?

Bleeding gums	Yes	No
Bad Breath	Yes	No
Soreness in jaw joint	Yes	No
Grinding your teeth	Yes	No
Snoring	Yes	No

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

Do you think your dental health effects
Your overall health? Yes No

How often do you get your teeth cleaned? __________

When was the last time you had an oral cancer exam?
____

Is the brightness of your teeth important to you? Yes No

Do you smoke or use Tobacco in any form? Yes No

How many soft drinks or sweet drinks do you have daily? __________

If you could change anything about your teeth –
Would you make them: (Answer Yes or No)

Whiter __________

Straighter __________

Close Spaces __________

Replace black fillings with
Tooth colored ones __________

Repair chipped teeth __________

Replace missing teeth _________

Replace old crowns or caps
That don't match __________

Have less gum showing_________

Be able to chew better _________

Do you prefer to save your teeth? Yes No

Have you had any teeth removed? Yes No

Has a dentist or hygienist ever made you feel
Uncomfortable about your teeth or
Homecare? Yes No

What can we do to avoid this?
____
____

Date of your last cleaning:___________________________

If there were a way to whiten your teeth for a reasonable investment, would you be interested? ___________________

What is the most important thing to you about your future smile and dental health? ______________________________

What is the most important thing about your dental visit today? ____