Kingwood Dental Specialists

Oral Surgery ~ Endodontics ~ Periodontics

NAME_____ Referred to us by_____

Parent/Guardian if minor_____

Date of birth_____ ____Single ____Married ____Minor *(under 18)*

Address_____ Apt# _____ Home ph_____

City_____ State____ Zip_____ Cell ph _____

____Male _____Female SS# _____ Email Address

Emergency Contact _____ Relationship _____ Emergency ph

Pharmacy Name _____ Pharmacy Number_____

Please complete all items below for Dental Insurance processing

DENTAL INSURANCE ____None ____Dental Plan PPO

Policy holder_____ Do you have your dental ID card? _____

Date of Birth_____ Are you covered under a 2nd plan? _____

Policy holder SS## _____ Patient relationship to policy holder ___Self ___Spouse ___Dependent

Policy holder Ins. ID#_____

Policy holder employer_____

Insurance company_____ Insurance company ph_____

Group #_____

INSURANCE AGREEMENT

We will gladly file a claim for your services on your behalf as a courtesy and accept assignment of benefit (payment to be sent to the practice) from your insurance company to supplement out of pocket expenses. However, it is important to understand insurance is a contract between you, your employer, and the insurance company. We are not a participant in some of these contracts making our practice **out of network**.
Also, it is your responsibility to notify us of any changes or cancellations in your insurance prior to the start of your appointment.
We recommend treatment based on individual needs and not insurance benefits. We provide you an **estimate** of insurance benefits based on the information available. We **cannot guarantee** the amount your insurance will pay/cover due to many limitations and exclusions in your policy. **Any balance not paid by your insurance is still your responsibility.** If you do not approve of this policy, we are happy to assist you in filing your own insurance claim.

☐ **I understand and acknowledge Kingwood Dental Specialists is out of network with some insurance companies and cannot guarantee the amount my insurance will pay/cover due to many limitations and exclusions in my policy.**

Signature: _____ Date: _____

Consent for Use and Disclosure of Health Information

Health Insurance Portability and Accountability Act

Please read the following carefully.

Purpose of Consent

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

1414 Green Oak Terrace Court, Suite 400 77339 281.359.1011 Office 281.358.1085 Fax

Consent

I, _____**(please print)**, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: X_____**Date: X**_____

If a personal representative on behalf of the patient is signing this consent, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Right to Revoke

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that **we may decline to treat or continue treating you if you revoke this Consent.**

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. **I also understand that you may decline to treat or continue to treat me after I have revoked my consent.**

Signature: _____Date: _____

If a personal representative on behalf of the patient is signing this revocation of consent, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Kingwood Dental Specialists

Oral and Maxillofacial Surgery
Periodontics
Health Questionnaire

Patient Name:_____ DOB: _____/_____/_____ Age: _____

Sex: M | F Height:_____ft _____in Weight: _____lbs Date: _____/_____/_____

Directions: Please check the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely. Answers to the following questions are for our records and will be considered confidential.

1. Are you in good health?	□ Y □ N
A. If no, please explain? _____	
B. Has there been any changes in your general health?	□ Y □ N
a. If yes, please explain? _____	
2. My last physical examination was on: _____	
3. Are you now under the care of a physician?	□ Y □ N
A. If yes, why? _____	
B. The name and phone number of my physician is: _____	
4. Have you ever had a serious illness or have you been hospitalized?	□ Y □ N
A. If yes, what and when? _____	
5. Have you ever had surgery before?	□ Y □ N
A. If yes, what for? _____	
6. Have you ever had Anesthesia before?	□ Y □ N
A. If yes, what for? _____	
7. Have you ever had a complication from surgery?	□ Y □ N
A. If yes, what? _____	
8. Have you or any of your immediate family members ever had complications or problems with anesthesia?	□ Y □ N
A. If yes, what? _____	
9. Do you currently have a cough, sore throat, laryngitis or infection of any kind?	□ Y □ N
10. Do you ever cough up blood?	□ Y □ N
11. High/Low blood pressure □ HIGH □ LOW	□ Y □ N
12. Venereal Disease	□ Y □ N
13. AIDS or HIV+	□ Y □ N
14. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?	□ Y □ N
A. If yes, what?	
B. Do you bruise easily?	□ Y □ N
C. Have you ever required a blood transfusion?	□ Y □ N
If yes, why and when? _____	
15. Do you have any history of anemia or bleeding disorders?	□ Y □ N
A. If yes, what? _____	
16. Have you had surgery, radiation and/or x-ray treatment for a tumor, growth or other condition of your head or neck?	□ Y □ N
A. If yes, what? _____	
17. Are you taking any drug(s) or medication(s)?	□ Y □ N
A. If yes, what? _____	
18. Are you taking any of the following? If yes, please list medication(s.)	
A. Antibiotics or sulfa drugs _____	□ Y □ N
B. Anticoagulants/Blood thinners such as Aspirin, Plavix, Coumadin, etc. _____	□ Y □ N
C. Chemotherapy Drugs _____	□ Y □ N
D. Immunosuppressive drugs _____	□ Y □ N
D. Cortisone (steroids) _____	□ Y □ N
E. Digitals or drug(s) for heart trouble _____	□ Y □ N
F. Fen-Phen (now or in the past) or related drug such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramine), and Redux (dexfenfluramine) _____	□ Y □ N
G. High/Low blood pressure medication _____	□ Y □ N
H. Insulin, Tolbutamide (Orinase) or similar drug _____	□ Y □ N
I. Nitroglycerin _____	□ Y □ N
J. Oral Contraceptives _____	□ Y □ N
K. Osteoporosis Drugs (Actonel, Aredia, Boniva, Disronel, Fosamax, Prolia, Reclast, Zometa, etc.)	□ Y □ N
L. Tranquilizers, Muscle Relaxants or Anxiety medication_____	□ Y □ N

Official Use ONLY:

Patient Name:_____ DOB: _____/_____/_____

M. Other _____ □ Y □ N

19. Do you have a heart murmur or mitral valve prolapse? □ Y □ N
A. If yes, what? _____

20. Do you have any implants and/or prosthesis (i.e. hip or knee joints replacements) □ Y □ N
A. If yes, what? _____

21. Do you drink alcoholic beverages? □ Y □ N
A. If yes, how often? □ daily □ weekly □ monthly □ 1-3 □ 4-6 □ 7+

22. Do you smoke? □ Y □ N
A. If yes, how many packs per day?
B. How many years? □ 1-5 □ 6-10 □ 11-15 □ 16-20 □ 21-25 □ 26+

23. Do you use any street or illicit drugs? □ Y □ N
A. If yes, what and when did you last use? _____

24. Do you have, or have you had, any of the following diseases or problems?
A. Seasonal Allergies □ Y □ N
B. Arthritis □ Y □ N
C. Asthma □ Y □ N
D. Inflammatory rheumatism (painful, swollen joints) □ Y □ N
E. Heart attack or stroke □ Y □ N
1. If yes what and when? _____
F. Cardiovascular disease (heart trouble, angina, coronary occlusion, atherosclerosis) □ Y □ N
1. Do you have pain in the chest upon exertion? □ Y □ N
2. Are you ever short of breath after mild exercise? □ Y □ N
3. Do you get short of breath when you lie down or do you require extra pillows when you sleep? □ Y □ N
G. Congenital heart lesions □ Y □ N
H. Rheumatic fever or rheumatic heart disease □ Y □ N
I. Diabetes □ Y □ N FSGB_____mg/dl at _____ □ NA
J. Fainting spells □ Y □ N
K. Seizures □ Y □ N
L. Hepatitis, jaundice, or liver disease □ Y □ N
M. Hives or skin rash □ Y □ N
N. Kidney, Liver, or Lung disease □ Y □ N
a. If yes, what? _____
O. Stomach ulcers □ Y □ N
P. Tuberculosis □ Y □ N
Q. COPD □ Y □ N

25. Are you allergic or have you reacted adversely to the following? If yes, please list medication(s.) □ Y □ N
A. Aspirin _____ □ Y □ N
B. Iodine _____ □ Y □ N
C. Codeine _____ □ Y □ N
D. Sulfa Drugs _____ □ Y □ N
E. Penicillin or other antibiotics _____ □ Y □ N
F. Latex _____ □ Y □ N
G. Local Anesthetic _____ □ Y □ N
H. Barbiturates, sedatives, sleeping pills _____ □ Y □ N
I. Other _____ □ Y □ N

26. Are you allergic to any foods (eggs, soy, fish?) □ Y □ N
A. If yes, what? _____

27. Have you had any serious trouble associated with previous dental treatment? □ Y □ N
A. If yes, explain _____

28. Are you pregnant, possibly pregnant or nursing? □ Y □ N
A. If yes, when are you due?_____

Official Use ONLY:

I certify to the best of my knowledge the above information is correct and if there are any changes in the above, I agree to notify the Surgeon/Dentist before my next visit.

Patient/Guardian Signature Date Doctor Signature Date

BP: / P:
Date: / /
Assistant:

Updates:

Patient/Guardian Signature Date Doctor Signature Date BP: / P: Assistant:

Patient/Guardian Signature Date Doctor Signature Date BP: / P: Assistant:

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Oral Surgery ~ Endodontics ~ Periodontics

PATIENT CANCELLATION POLICY

Please understand that when we schedule your appointment, we are reserving time for your particular needs. We reserve a room for you and your records and insurance is verified and prepared. We kindly ask that if you must change an appointment, please give us at least 48 business hours' notice. This courtesy makes it possible to give your reserved time to another patient who is in need of it. Please call the office if you need to cancel or reschedule an appointment.

We understand that emergencies happen, and will work with any patient that may need to move an appointment. Thank you for your understanding and in order to provide the best experience for all of our patients, we ask that you arrive at your scheduled appointment time.

☐ **I understand that there is a $40 charge (per appointment) if I cancel without providing a 48 business hours' notice or if I do not show for my appointment. The payment must be made in order to schedule my next appointment.**

Printed Patient Name(s): _____

Signature: _____ Date: _____

Pre-Surgical Deposit Policy

(For Oral Surgery and Perio patients only)

To better accommodate our patients and to ensure our schedule is running efficiently, our policy at Kingwood Dental Specialists is to collect a pre-surgical deposit of 50% (of patient portion) from all patients prior to scheduling any surgical procedures.

The deposit will be applied to any services related to the surgery. Remainder of the balance will be due at date of surgery. Cancellation of surgery must be done 5 business days prior to the day of surgery otherwise the deposit will be forfeited.

☐ **I understand that I will be forfeiting my deposit if I cancel my surgery appointment within 5 business days of surgery.**

Printed Patient Name(s): _____

Signature: _____ Date: _____