

# 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 2<sup>nd</sup> 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

<p>M. Other _____ <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>19. Do you have a heart murmur or mitral valve prolapse? <input type="checkbox"/> Y <input type="checkbox"/> N          A. If yes, what? _____</p> <p>20. Do you have any implants and/or prosthesis (i.e. hip or knee joints replacements) <input type="checkbox"/> Y <input type="checkbox"/> N          A. If yes, what? _____</p> <p>21. Do you drink alcoholic beverages? <input type="checkbox"/> Y <input type="checkbox"/> N          A. If yes, how often? <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7+</p> <p>22. Do you smoke? <input type="checkbox"/> Y <input type="checkbox"/> N          A. If yes, how many packs per day?          B. How many years? <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-15 <input type="checkbox"/> 16-20 <input type="checkbox"/> 21-25 <input type="checkbox"/> 26+</p> <p>23. Do you use any street or illicit drugs? <input type="checkbox"/> Y <input type="checkbox"/> N          A. If yes, what and when did you last use? _____</p> <p>24. Do you have, or have you had, any of the following diseases or problems?          A. Seasonal Allergies <input type="checkbox"/> Y <input type="checkbox"/> N          B. Arthritis <input type="checkbox"/> Y <input type="checkbox"/> N          C. Asthma <input type="checkbox"/> Y <input type="checkbox"/> N          D. Inflammatory rheumatism (painful, swollen joints) <input type="checkbox"/> Y <input type="checkbox"/> N          E. Heart attack or stroke <input type="checkbox"/> Y <input type="checkbox"/> N          1. If yes what and when? _____          F. Cardiovascular disease (heart trouble, angina, coronary occlusion, atherosclerosis) <input type="checkbox"/> Y <input type="checkbox"/> N          1. Do you have pain in the chest upon exertion? <input type="checkbox"/> Y <input type="checkbox"/> N          2. Are you ever short of breath after mild exercise? <input type="checkbox"/> Y <input type="checkbox"/> N          3. Do you get short of breath when you lie down or do you require extra pillows when you sleep? <input type="checkbox"/> Y <input type="checkbox"/> N          G. Congenital heart lesions <input type="checkbox"/> Y <input type="checkbox"/> N          H. Rheumatic fever or rheumatic heart disease <input type="checkbox"/> Y <input type="checkbox"/> N          I. Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N FSGB _____ mg/dl at _____          NA          J. Fainting spells <input type="checkbox"/> Y <input type="checkbox"/> N          K. Seizures <input type="checkbox"/> Y <input type="checkbox"/> N          L. Hepatitis, jaundice, or liver disease <input type="checkbox"/> Y <input type="checkbox"/> N          M. Hives or skin rash <input type="checkbox"/> Y <input type="checkbox"/> N          N. Kidney, Liver, or Lung disease <input type="checkbox"/> Y <input type="checkbox"/> N          a. If yes, what? _____          O. Stomach ulcers <input type="checkbox"/> Y <input type="checkbox"/> N          P. Tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> N          Q. COPD <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>25. Are you allergic or have you reacted adversely to the following? If yes, please list medication(s.) <input type="checkbox"/> Y <input type="checkbox"/> N          A. Aspirin _____ <input type="checkbox"/> Y <input type="checkbox"/> N          B. Iodine _____ <input type="checkbox"/> Y <input type="checkbox"/> N          C. Codeine _____ <input type="checkbox"/> Y <input type="checkbox"/> N          D. Sulfa Drugs _____ <input type="checkbox"/> Y <input type="checkbox"/> N          E. Penicillin or other antibiotics _____ <input type="checkbox"/> Y <input type="checkbox"/> N          F. Latex _____ <input type="checkbox"/> Y <input type="checkbox"/> N          G. Local Anesthetic _____ <input type="checkbox"/> Y <input type="checkbox"/> N          H. Barbiturates, sedatives, sleeping pills _____ <input type="checkbox"/> Y <input type="checkbox"/> N          I. Other _____ <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>26. Are you allergic to any foods (eggs, soy, fish?) <input type="checkbox"/> Y <input type="checkbox"/> N          A. If yes, what? _____</p> <p>27. Have you had any serious trouble associated with previous dental treatment? <input type="checkbox"/> Y <input type="checkbox"/> N          A. If yes, explain _____</p> <p>28. Are you pregnant, possibly pregnant or nursing? <input type="checkbox"/> Y <input type="checkbox"/> N          A. If yes, when are you due? _____</p>	<p><b>Official Use ONLY:</b></p>
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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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## **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-Treatment Deposit Policy**

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

The deposit will be applied to any services related to the treatment. The remainder of the balance will be due on the day of treatment. Cancellation of treatment must be done 5 business days prior to the day of treatment otherwise the deposit will be forfeited.

**I understand that I will be forfeiting my deposit if I cancel my treatment appointment within 5 business days of scheduled treatment date.**

Printed Patient Name(s): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_