Patient Information

Patients Last Name: First: M:

Birth Date: Sex: M/F Marital Status:

Address: City/State/Zip:

Home Phone: Work Phone: Cell Phone:

E-mail Address:

Social Security: DL #/State: Exp. Date:

Employer:

Preferred Contact: ☐ Phone ☐ Text Message ☐ Email

Spouse/Guardian Information

Name: D.O.B:

Social Security: Employer:

Cell Phone: Work Phone:

Referring Dentist: Phone:

Family Physician: Phone:

Pharmacy Name: Phone:

Insurance Information

Insured's Name: D.O.B.:

Insurance Company Name: Insurance Phone:

Address: City/State/Zip:

Employer: ID#

Group #:

In case of Emergency (list a relative or local friend not living at same address)

Name: Cell Phone:

The above information is true to the best of my knowledge. Payment for services is due at the time services are rendered. There is a $35 fee for NSF checks returned. I understand that not all services performed may be covered by my insurance contract, and fees charged may differ from the UCR fees determined by my insurance company. I authorize and assign insurance payments directly to Associates in PIE, PLLC and I understand that I am responsible for any balance. I authorize Associates in PIE, PLLC or my insurance company to release any information required to process my claims.

Patient/Guardian Signature: **Date:**

Associates in PIE
Periodontics, Implantology & Endodontics

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Height: _____ **Weight:** _____

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Associates in PIE
Periodontics, Implantology & Endodontics

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Name: _____

Purpose of Consent: By signing this form, you are acknowledging receipt of notice of privacy practices and consenting 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 the other important matters about your protected health information. A copy of our Notice accompanies this consent. 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 our 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 our office:

Tel: 972-538-3700 **Fax:** 972-538-3771 **Address:** 1005 Long Prairie Rd, Ste. 100, Flower Mound, TX 75022

Right to Revoke: You may 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, but that we may not be able to treat you or to continue treating you if you revoke this Consent.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____ have received a copy of this office's Notice of Privacy Practices.
(Please Print Name)

_____
(Signature)

_____
(Date)
Please allow the following to access information on my behalf_____

For Office Use Only

We attempted to obtain written acknowledgment 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_____

Associates in PIE
Periodontics, Implantology & Endodontics

General Cancellation/No Show Policy

When we schedule your appointment, we reserve time on the schedule specifically for you. We understand that situations may arise that will keep you from making it to your appointment. If you are not able to make it to your appointment, we require 24 hours notice or a $100 cancellation fee will be charged to your account. Cancellations must be made by phone to our front office.

Periodontal Surgery Appointments

A surgery deposit of $250.00 will be collected when making your appointment for periodontal surgery. This amount will be deducted from the cost of the surgery when you come for your appointment. Since this time has been set aside especially for you, a minimum of 72 hours is required if you need to cancel or reschedule your appointment. If you do not cancel in that time frame, your account will be charged $250.00 per hour scheduled.

******Our answering service does not accept cancellations.**

_____ _____

Signature **Date**