

Montgomery Park Dental Care
2016 N. Loop 336 W., Conroe, TX
936-756-6867 Fax: 936-756-6950

PATIENT INFORMATION

First Name: _____

Last Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cellular Phone: _____

Pt Birth Date: _____ Age _____

E-mail: _____

Male Female

Single Married Divorced Widowed Separated

Emergency Contact: _____

Please Note:

Our office is happy to file your insurance for you as a courtesy. Unfortunately, insurance plans change frequently and are rewritten to satisfy the company purchasing the insurance. We attempt to keep up with the dental benefits of your insurance plan. Our office cannot possibly be aware of the many variations included in all dental plans. KNOW YOUR INSURANCE!!! If there are questions our office cannot answer, contact your H.R. department.

Any complaints about a Dentist or Dental Hygienist should be directed to:
The State Board of Dental Examiners: (512) 463-7452

Medical History on Reverse Side

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996, (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosure to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Additional Disclosure Authority

In addition to the allowable disclosures described in the "Notice of Privacy Practices," I hereby specifically authorize disclosure of my protected dental care information to the person/s indicated below:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Name: _____

Signature: _____

Date: _____

Relationship to Patient: _____

FINANCIAL POLICY

In order to provide you with the highest quality dental care on an understandable financial basis, we provide our patients with an estimate of fees and arrange for a payable schedule. By establishing a clearly defined method of payment, we hope to eliminate confusion and simplify insurance claims so that we will both have a definite understanding. We accept cash, check, and all major credit cards also, we offer financing through Care Credit, a conveniently monthly payment option.

Our office is happy to file your insurance claim as a courtesy for you. Unfortunately, insurance plans change frequently and are rewritten to satisfy the company purchasing the insurance. We attempt to keep up with the dental benefits of your insurance plan. Our office cannot possibly be aware of the many variations included in all dental plans. **KNOW YOUR INSURANCE!!!** If there are questions our office cannot answer, contact you H.R. department. Insurance assignment is accepted for a period not to exceed 60 days. If insurance has not paid within 60 days of the filing date the patient is expected to pay the balance in full.

We are NON Participating Providers with all major HMO insurance plans.

We are In-Network with Assurant, Aetna, Cigna and Guardian

Failure to arrive for your scheduled appointment or change/cancel an appointment without a 24 hour notice will result in a \$50 charge. After 3 no show appointments we will no longer appoint you at this office.

Your estimated payment due the day of service is based upon verification of insurance benefits.

Thank You,
Montgomery Park Dental Care

Print Patient Name

Patient/Guardian Signature

Date

Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

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?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?

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, Sulfa Drugs, Local Anesthetics

Other? If yes

Do you use controlled substances? If yes

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

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

Have you ever had any serious illness not listed? If yes

Comments:

Empty box for patient 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:

X _____

Date: _____