Getting Acquainted Questionnaire

Welcome!

Please fill out these forms Prior to your appointment and bring them with you.

Today's Date _____

Patient's Name _____ Name I like to be called _____ Male__ Female__

Age___ Birthdate _____ Marital Status _____

Home address _____ City _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

E-mail _____ How would you like to be contacted? _____

If student, name of school _____ How did you hear about our office? _____

Patient's Hobbies/Interests:

_____

_____

_____

Patient's Children- names and Ages

_____

_____

_____

Person Responsible for Account

Name _____ Social Security # _____ Birthdate _____

Employer _____ Occupation/Position _____ Cell Phone _____

Name of Spouse _____ Employer _____ Occupation _____ Cell Phone _____

Do you have dental insurance that may cover part of our Professional Services? Yes _____ No _____

If yes, please bring your Dental Insurance card or insurance information with you to your appointment.

Whom may we contact in case of an emergency? _____ Phone _____

Consent for Treatment and Office Financial Policy

Consent for Treatment

1. I hereby authorize Richard M. Jones, DDS or any designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs. X-rays, study models and photographs are for the use by and property of Dr. Jones.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetics embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Office Financial Policy

1. Patients and/or their account holders are financially responsible for payment of all services rendered. Our office policy requires payment at the time of service unless other arrangements have been determined in advance of treatment date.

2. **Dr. Jones is an out-of-network provider, meaning that in some cases, there may be a difference in the benefit amount that an insurance carrier will pay when compared to an in-network provider. Our office can send a Pre-Determination to your insurance carrier to help determine your insurance benefits available out of network.**

3. As a courtesy, our office will file any applicable dental insurance claims for you and your dependent(s). Our office will request assignment of benefits from your carrier, in most cases. When treatment is provided, patients will be asked to pay an estimated amount towards their out-of-pocket cost. **It is important that patients understand that our office cannot estimate the exact amount of any benefits payable by any insurance carrier.** We highly recommend, and in some cases will require a Pre-Treatment Estimate or Pre-Determination be submitted on your behalf to your insurance carrier prior to treatment, as this is the best way to know for certain what benefits your policy covers and the resulting cost to you. **Patients are financially responsible for any and all amounts not paid by their insurance company.** In the case that your insurance company should pay more that estimated, resulting in a credit balance, you will be promptly reimbursed.

4. Our office may charge for failed or canceled appointments (without the required 24 hours notice), according to the fee schedule listed below;

   Dr. Appointments charged at a rate of $50 for every ½ hour of scheduled time missed.
   The fee for a failed appointment with a hygienist will be $50.

My signature below confirms that I have read, understand, and agree to the Consent to Treatment and the Office Financial Policies listed above.

Patient name (print) _____

Parent or Responsible Party (signature) _____

Date _____

Relationship to Patient _____

Your current health: ☐ GOOD ☐ FAIR ☐ POOR
Current Physician: _____
Physician phone #: _____
Please list any prescription medications (and for what purpose) that you are currently taking:

_____
_____
_____
_____
_____

Previous Dentist: _____
City/State: _____
Last Dental Visit: _____

Current Dental health: ☐ GOOD ☐ FAIR ☐ POOR
Are you happy with your smile? ☐ YES NO
If no, please tell us why:

_____
_____

Women:
Are you pregnant? ☐ YES ☐ NO Due date: _____
Are you nursing? ☐ YES ☐ NO

Circle if you have or have had been treated for any of the following disease of conditions.

Abnormal Bleeding	Hemophilia
Alcohol/Drug Abuse	Hepatitis A, B, or C
Anemia	High Blood Pressure
Artificial joints/bones/valves	HIV/AIDS
Asthma	Kidney Problems
Cancer	Liver Disease
Congenital Heart Defect	Low Blood Pressure
Diabetes Type 1 Type 2	Migraines
Difficulty Breathing	Mitral Valve Prolapse
Emphysema	Pacemaker
Epilepsy	Psychiatric Problems
Fainting spells	Radiation Problem
Frequent Headaches	Rheumatic Fever
Glaucoma	Scarlet Fever
Glum Disease	Seizures
Heart Attack	Stroke
Heart Murmur	Thyroid Problems
Heart Surgery	Tuberculosis(TB)

Do you have any medical condition that we should be aware of?

_____

Do you smoke or chew tobacco? ☐ YES ☐ NO
Do you need to be pre – medicated for Mitral Valve Prolapse, Heart Murmur, or any kind of joint bone/valve replacement? ☐ YES ☐ NO
If you had joint replacement surgery, what kind and how long ago?

_____

Would you like your teeth to be whiter?	**Y N**		
Would you like for you teeth to be straighter?	**Y N**		
If you had orthodontics, how long ago?	___		
Do you clench or grind your teeth?	**Y N**		
Do you have pain in your jaw, face, or teeth?	**Y N**		
Do you have a bad odor/taste in your mouth?	**Y N**		
Do your gums bleed when brushing or flossing?	**Y N**		
Are your teeth sensitive to cold?	**Y N**		
Does food catch between your teeth?	**Y N**		
Does your spouse complain about you snoring?	**Y N**		
Have you ever done a sleep study?	**Y N**		
Do you use a C-PAP when you sleep?	**Y N**		

Do you have silver or discolored fillings or unnatural looking crowns or bridges that you wish looked different? ☐ **Y** ☐ **N**
If yes, please explain:

_____
_____

Please tell us about any other dental concerns that you may have or any information that you feed is important for us to know:

_____
_____
_____

Please tell us what you are looking for in a dental office, what is the most important to you?

_____
_____
_____

Please circle any of the following which you are allergic to:

Aspirin	Codeine	Dental Aesthetics	Erythromycin
Iodine	Latex	Penicillin	Sulfa

Please list any other allergies:

_____
_____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I understand that it is my responsibility to notify the doctor of any change in my health or medication. Should further information be needed, you have my permission to ask the respective health care provider or agency, who my release such information to you.

Parent/Guardian Signature: _____ Date: _____

History Review
Date: _____

Notice of Privacy Practices Acknowledgement

Richard M. Jones D.D.S.
Westlake Hills Dental Arts
1301 Capital of Texas Highway, Suite A-132
Austin, Texas 78746

I understand that, under the Health Insurance Portability & Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

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

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 above 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 disclosed 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 to abide by such restrictions.

Patient Name:

Relationship to Patient: _____

Signature:

Date:

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date	Initials	Reason