Getting to Know You

Patient Name_____
Mailing Address _____
City_____ ST_____ Zip_____
Physical Address _____
City_____ ST_____ Zip_____
Home Phone_____
Cell Phone_____
Work Phone _____
Email_____
Social Security Number _____
Birthdate_____ ☐ Male ☐ Female
Driver's License # _____
Employer _____

How did you hear about our office?

_____

If a friend or family member referred you, we would like to thank them. To whom may we send our thanks?

_____

Communication

Which of the following are methods we can contact you for appointment confirmations and other office communications? Check all that apply.

☐ Text ☐ Email ☐ Phone ☐ Mail

Financially Responsible Party

Name_____
Relationship _____
Phone Number _____
Address _____
City _____ ST _____ Zip_____

Emergency Contact

Name_____
Relationship _____
Phone Number _____
Address _____
City _____ ST _____ Zip_____

Dental Insurance Information

Insured's Name_____
Relationship to Patient_____
Birthdate_____ ☐ Male ☐ Female
Employer_____
Work Phone _____
Insurance Carrier_____
Ins. Co Address_____
City_____ ST_____ Zip_____
Policy/ID #_____
Group #_____

Consent

I hereby authorize the performance of dental services upon the above-named patient and whatever procedures the judgement of the doctor may decide in order to carry out these procedures. I understand that the initial visit requires x-rays in order to complete the examination, diagnosis, and treatment plan. I authorize and request the administration of any x-rays and local anesthetics as deemed necessary and advisable by the doctor. I also authorize assignment of my insurance benefits directly to the provider for services rendered. I fully understand that I am responsible for all charges to my account regardless of the decision of my insurance company to pay or deny for any reason.

✘_____

Patient / Guardian Signature Date

Patient Health History

Patient Name:_____ Date _____

Medications

Please list **ALL** medications or supplements you are currently taking:

Med_____ For_____
Med_____ For_____
Med_____ For_____
Med_____ For_____
Med_____ For_____
Med_____ For_____

Have you ever taken a bisphosphonate medication (e.g. Fosamax, Boniva)? ☐ Yes ☐ No

Medical History

Physician's Name _____
Address_____
Phone_____
Date of last exam _____
Have you ever been hospitalized? ☐ Yes ☐ No
Reason?_____
_____
(Women) Are/could you be pregnant? ☐ Yes ☐ No
(Women) Are you nursing? ☐ Yes ☐ No

Please check if you have or have had any of the following medical conditions:

☐Rheumatic Fever
☐Heart Murmur
☐Mitral Valve Prolapse
☐Diabetes
☐High Blood Pressure
☐Low Blood Pressure
☐Any Type of Transplant
☐Drug Addiction
☐Alcoholism
☐Use of Tobacco Products
☐Hepatitis (Type: _____)
☐Liver Disease
☐Kidney Disease
☐Asthma
☐Allergies or Hives
☐Anemia

☐Arthritis
☐HIV Positive/AIDS
☐Venereal Disease
☐Blood Transfusion
☐Heart Valve Replacement
☐Heart Problem (_____)
☐Dialysis
☐Chemotherapy
☐Radiation Treatment
☐Thyroid Disease
☐Epilepsy or Seizures
☐Fainting or Dizzy Spells
☐Pace Maker / Heart Surgery
☐Sinus Problems
☐Excessive Bleeding
☐Stroke

☐Lung Disease
☐Breathing Problems
☐Tuberculosis (TB)
☐Psychiatric Treatment
☐Aspirin/Anticoagulant Therapy
☐Ulcers or Stomach Problems
☐Any type of Implant
☐Cancer (Type:_____)
☐Any Artificial Hip, Knee, or other Joint
☐Other medical condition not listed:_____
_____
_____
_____

Do you have and of the following allergies?
☐ Seasonal ☐ Ibuprofen ☐ Penicillin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Other Medications
Please list any other allergies: _____

✘_____ _____
Patient / Guardian Signature Date

Dental History

What is your main goal for today's visit?

_____

When was your last dental exam?

_____

How often do you have your teeth cleaned?

_____

Do you have any pain in your mouth? Where?

_____

Do you have any pain of the TMJ?

_____

What do you like most about your smile?

_____

What would you change about your smile?

_____

What did you like about your previous dentist?

_____

What did you dislike about your previous dentist?

_____

Are you interested in whitening your teeth?

_____

Are you interested in straightening your teeth?

_____

Do you clench or grind your teeth? When?

_____

Do you snore or been told that you snore?

_____

Do you frequently have mouth sores or growths?

_____

Have you been told to take antibiotics prior to dental treatment? _____

I understand that the information I have provided on these forms 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. Should further information be necessary, you have my permission to request that information from the respective health care provider and for them to release the information to you. U promise to notify the doctor of any change in my health or medication.

✘_____ _____

Patient / Guardian Signature Date

Financial Agreement

Patient Name: _____

Financial Policies and Acknowledgments
We believe that all patients deserve to know, up front, our financial policies. Below are our policies relating to your dental care.

Payment
Your estimated portion is due in full as services are rendered. For your convenience, we accept cash, checks, debit cards, and credit cards. We also offer third party financing. Arrangements for financing through a third party must be made in advance of your appointment. Accounts with returned checks due to insufficient funds will be assessed a $30 fee

Dental Insurance
As a courtesy, we will file your primary insurance claim for you. We offer this service to you as a courtesy only, and it is not meant to be a substitute for payment. We will attempt to collect from your insurance carrier, their portion of the charges for your visit. We cannot guarantee that they will pay any amount for your treatment. Each plan has different exclusions and limitations and those exclusions and limitations change over time. Our office recommends dental treatment based on medical necessity and not on whether your insurance company will cover a procedure. It is your responsibility to know your dental coverage. It is your responsibility to pay any amount not covered by your insurance company regardless of the reason. We will instruct your insurance carrier to send all payment directly to our office for reimbursement. In the event that an insurance company sends payment directly to you, the payment must be forwarded/assigned to our office.

Missed Appointment Fee
Our office requests 24 hours advance notice if you are unable to keep you scheduled appointment. If less than 24 hours notice is given, a $30.00 fee will be charged to your account. Patients with three of more missed appointments may be assisted in finding dental care from another doctor.

Emergency/After Hours Care
If you or your child is seen for an emergency visit after regular business hours, an “after hours” fee is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time of service.

Past Due Accounts
If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all collection costs which are incurred.

✘ _____

Patient / Guardian Signature Date

_____

Printed Name Relationship to Patient

Authorization to Release Media

Patient's Name: _____

Doctor's Name: Ryan Dahle, DMD and Dahle Dental

I hereby authorize Dahle Dental and Ryan Dahle, DMD or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, videos, and comment cards will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

☐ I do not mind if my photographs are used in any of the above stated situations.

☐ I only agree to have my teeth shown without any identifying features.

✘ _____

Patient / Guardian Signature Date

_____

Printed Name Relationship to Patient

Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: _____Address: _____

Section B: To the Patient – Please Read 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 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 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 calling our office.

Phone 903-892-1052

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. 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 you or to continue treating you if you revoke this Consent.

Section C: Acknowledgement of Receipt of HIPAA Policies and Procedures

I, _____, have been given the opportunity to review and request a copy of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to you use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

✘ _____

Patient / Guardian Signature Date

Section D: Additional People to Have Access to Information

I would like to give the following persons access to my personal health information

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

✘ _____

Patient / Guardian Signature Date