***Dental Studio 121***

***3680 TX-121, Suit 100***

***Plano, TX 75025***

***Ph:469-333-3300***

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

**Patient Information:**

Patient’s Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_\_\_\_

Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Driver’s License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred contact method: ( ) Home ( ) Work ( ) Cell ( ) E-mail ( ) Text

Employer: ­­­­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single Married Widowed Divorced Other ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for your referral? Another patient/friend Name of That Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Internet Search  Specialist Recommendation  Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcard



 Other ­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance** *(if applicable)***:**

Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Employer:­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Complete the following for the* ***Policy Holder*** *(if different from patient or responsible party):*

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a Secondary Dental insurance ? Y or N

If Yes , then - Secondary Dental Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Dental Studio 121***

Patient Name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information:**

Name and Phone # of Treating Medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Have you ever had any of the following:*

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies | Drug or Alcohol Abuse | Osteoporosis | Bacterial Endocarditis |
| Abnormal Bleeding | Emotional Problems | Panic Attacks/Anxiety | Heart Murmur |
| ADD/ADHD | Epilepsy or Seizures | Parkinson’s Disease | Irregular Heart Beat |
| ALS | Frequent Headaches | Radiation Treatment | High Blood Pressure |
| Anemia | Glaucoma/Eye Disorders | Respiratory Problems | High Cholesterol |
| Arthritis | Hearing Difficulties | Sinus Problems | Low Blood Pressure |
| Artificial Joint(s) | Hepatitis – Type: \_\_\_\_\_\_\_ | Sleep Apnea | Artificial Heart Valve(s) |
| Type and Year: \_\_\_\_\_\_\_\_\_ | HIV/AIDS | Stomach Problems/GERD | Congenital Heart Lesion |
| Asthma | Immunosuppressive | Stomach Ulcer/Colitis | Mitral Valve Prolapse |
| Blood Clot | Disorders | Stroke | Heart Attack |
| Cancer | Kidney Disease | Thyroid Problems | Year: \_\_\_\_\_\_\_\_\_\_\_ |
| Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Liver Disease or Jaundice | Tobacco Use | Angina/Chest Pain |
| Dementia or Alzheimer’s | Lyme Disease | Type & Amount: \_\_\_\_\_\_\_\_ | Pacemaker |
| Depression | Migraines | Venereal Disease/ STD | Heart Surgery |
| Diabetes | MS | Are You Pregnant? | Congestive Heart Failure |
| Dizziness or Fainting | Neurological Disorders | Due Date: \_\_\_\_\_\_\_\_\_ | Rheumatic Fever |

*Are you allergic to any of the following:*

|  |  |  |
| --- | --- | --- |
| Amoxicillin | Latex | Seasonal (dust, pollen, dander) |
| Aspirin | Local anesthetic (Novocaine) | Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Clindamycin | Penicillin | Other ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ |
| Codeine | Sulfa | Other ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Please list any prescription medications and over the counter supplements you are taking:*

­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you been admitted to a hospital, had surgery or needed emergency care in the past two years? Yes No

*If yes, please explain*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other health concerns that need further discussion:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Dental Studio 121***

Patient Name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History** (ages 13+):

What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Cleaning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Full Mouth Series of X-rays or PAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist Name and Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Now or in the past, have you ever had/used*:

|  |  |  |  |
| --- | --- | --- | --- |
| Sensitivity to cold or hot | Clench or Grind Teeth | Sleep study performed | Whitening products |
| Sensitivity to chewing | TMJ discomfort | Use CPAP |  |
| Bleeding or swollen gums | Jaw clicking or popping | Daytime sleepiness |  |
| Gum treatment or Surgery | Orthodontic Treatment | Tension Headaches |  |
| Food catching between teeth | Wear a retainer | Snoring | Prescription Fluoride |
| Canker Sores /Ulcers | Wear a night-guard | Bite Nails | Family History of Oral |
| Cold Sores/Fever Blisters/ | Injury to Jaw, Mouth or Face | Chew Ice | Cancer |
| Herpes Virus | Dry Mouth | Mouth breathing | Bad Breath |

How often do you have dental examinations? **­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How often do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other dental aids do you use? (rinses, waterpik, electric toothbrush, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you like the appearance of your smile? Yes No

Do you consider yourself a nervous dental patient? Yes No

Have you ever had an unpleasant dental experience? Yes No

Have you ever had problems with dental anesthesia or getting numb? Yes No

Is there anything else about having dental treatment that you would like us to know?Yes No

*If yes, please describe:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Are you interested in* ***information*** *on any of these topics:*

|  |  |  |
| --- | --- | --- |
| Invisalign Orthodontics | Fluoride Varnish |  |
| Teeth Whitening |  |  |
| Replacing missing teeth |  |  |
| Cosmetic Dentistry | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**Authorizations:**

I authorize release of information to all of my insurance companies.

I agree to pay for services rendered at the time of treatment.

I agree that I am ultimately responsible for my bill.

I authorize Dental Studio 121 and team to act as my agent in helping me to obtain payment from my Insurance companies.

I authorize payment directly to Dental Studio 121

I consent to all necessary dental procedures as deemed appropriate by Dr. Bafna or Dr Doshi.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Privacy Practices – HIPAA Form**

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

* Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
* Obtain payment from third-party payers for my health care services
* Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider’s *Notice of Privacy Practices* containing a morecomplete description of the uses and disclosers of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices*  and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Studio 121**

**Media & Social Release Form**

As a part of a vibrant company, we like to promote patient and office activities and celebrate achievements from time to time. For example, we might make a Social Media post like:

**“Congratulations to our No Cavity Club member, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for   
completing yet another cavity-free hygiene appointment! You are on   
your way to getting a big prize and a lifetime of good dental health!”**   
(A post like this may include a picture with the patient and their hygienist)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please print), do hereby grant permission to Dental Studio 121 to post mine or my child’s photo, First name, or other item to their FaceBook, Twitter, Insta-gram, or other Social Media pages. The **Health Insurance Portability and Accountability Act** still holds its place and I have been informed that absolutely no medical information will be released with the signing of this form.

Now, we do acknowledge that any patients that are under 18 years of age may not sign this without their parent present or parent’s permission. If you are a parent signing for your child please enter their name in the space provided below.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

Patient or Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_