Dental Oral Care
23535 IH -10 West, Suite 2202
San Antonio, TX 78257
(210)687-1444

New Patient Information

Today's Date _____

Patient Name _____ Date of Birth_____

SS#_____ Male ___ Female ___ Married ___ Single ___ Child ___Other___

Phone (Home) _____ (Work) _____ (Cell) _____

Address _____
Street City, State Zip Code

***E-mail Address (required):_____**

***Would you prefer to receive appointment reminders by email or by text message? _____**

Responsible Party Information

Name _____ Date of Birth _____ SS# _____

Insurance Information

Primary Insurance:
Name of the Insurance _____
Address _____ **Phone#** _____
Plan ID# _____ **Group #** _____
Name of the Insured _____ Date of Birth _____
SS# _____ Employer _____ (Phone) _____
Address _____ Relationship to Patient _____

Secondary Insurance:
Name of the Insurance _____
Address _____ **Phone Number** _____
Plan ID# _____ **Group #** _____
Name of the Insured _____ Date of Birth _____
SS# _____ Employer _____ (Phone) _____
Address _____ Relationship to Patient _____

Tell us how you heard about our office :

Internet	Insurance Website	Other: _____
Mail Brochure	Radio	Friend: _____

Dental Oral Care
23535 IH -10 West, Suite 2202
San Antonio, TX 78257

Patient Medical History

Patient Name:_____
Date of Last Dental Visit:_____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

AIDS	Liver Disease	Fainting
Allergies_____	Mental Disorders	Glaucoma
Anemia	Nervous Disorders	Growths
Arthritis	Pacemaker	Hay Fever
Artificial Joints	Pregnancy	Head Injuries
Asthma	Due Date:_____	Heart Disease
Blood Pressure	Radiation Treatment	Heart Murmur
Cancer	Respiratory Problems	Hepatitis
Diabetes	Rheumatic Fever	High Blood Pressure
Dizziness	Rheumatism	Jaundice
Epilepsy	Sinus Problems	Kidney Disease
Excessive Bleeding	Stomach Problems	Tumors
Stroke	Tuberculosis	Ulcers
Venereal Disease	Codeine Allergy	Penicillin Allergy
Sleep Apnea	OTHER:_____	

List of medications:_____

- Have you ever had any complications following dental treatment? Yes No
  If yes, please explain:_____

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
  If yes, please explain:_____

- Are you now under the care of a physician? Yes No
  If yes, please explain:_____

- Name of Physician:_____ Phone:_____

- Do you have any health problems that need further clarification? Yes No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____

Signature of patient, parent or guardian Date

Dental Oral Care
23535 IH -10 West, Suite 2202
San Antonio, TX 78257

Welcome To Our Practice

We are excited to welcome you as a new patient. We would like to get to know you a little, please take a few minutes to provide us with the answers to the following questions:

1. The primary reason for my visit today is to discuss: _____

_____

2. I would like to know more regarding the following procedures:

Teeth Whitening	Yes	No	
Veneers and Cosmetic Dentistry	Yes	No	
Dental Implants	Yes	No	
Snoring Reduction	Yes	No	
Braces	Yes	No	
Replacing Silver Fillings	Yes	No	
Replace Missing Teeth	Yes	No	
Sleep Apnea	Yes	No	Date Diagnosed_____

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you.

Dental Oral Care
HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out treatment
- Treatments (including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practice, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contract you at any time to obtain the most current notice of this copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out any treatment, payment and health care operations, but that you are not required to agree to these requested restrictions, However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred to the date I revoke this consent is not affected.

FINANCIAL POLICY

Your insurance policy is a contract between you and your insurance company. As filing your claims is a courtesy, we cannot accept responsibility for negotiating claims with your insurance company and/or other persons. Please understand that your insurance company does not guarantee coverage and/payment until they receive a claim. Taking this into consideration, you as the patient/guarantor are ultimately responsible for any payment your insurance company may not remit, regardless of claim status.

Payment is due at time services are rendered

CANCELLATION/ NO SHOW POLICY

With each appointment, time has been reserved specifically for you. We do not “double book” our patients, as we strive to provide the best standard of care. If you are unable to keep this appointment, we ask that you notify our office a minimum of 24 hours prior to the appointment. Failure to do so may result in a broken appointment fee of up to $50.

Signature: Date: