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Southlake, TX 76051
(817)251-9333

Patient Registration

First Name: __________________ Last Name: ______________________ DOB: ______

Sex (Circle): Male Female

Home Address: ____

City/State/Zip: ____

Home Phone: _______ ____________ ___ Cell Phone: _____________________________

Email: ____

Emergency Contact Name: ____

Home Phone: ___________________________ Cell Phone: _____________________________

Relation to Patient: ____

How Did You Hear About Us? ____

Referred by: ________________ Website___________________ Insurance ___________

Other: ____

Employment: ____

Hobbies: ____

Responsible Party (Insurance Policy Holder):

Full Name: ____

Social Security Number: _______________ Date of Birth: ___________________________

Insurance Company: _____________ Employer Name: ______________________________

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Dental Treatment Consent Form

Patient Name: ____

Health Information
I agree to disclose all previous illness and medical history. Undisclosed medical information and current medication, allergies or illness are risk factors.

1. **Drugs, Latex and Medicines**
I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine increases heartbeat, and depending on my health, may be dangerous to me.
2. **Needle Stick**
If someone is inadvertently struck with a needle used on me, I consent to have my blood drawn for analysis.
3. **Fillings, Crowns, and Un-anticipated Root Canals**
Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.
4. **Root Canals can Fail**
Root Canals can fail and may require additional treatment, or I may end up having the tooth extracted.
5. **Porcelain Crowns, Veneers, Bonding, and Cosmetic Fillings**
Porcelain crowns, veneers, cosmetic bonding and composite fillings are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding, or filling is placed, I understand the color cannot be changed.
6. **Gum Treatment and Requesting "Just a Cleaning"**
If I don't floss or if I smoke, I can expect to have deteriorating gum condition. I agree that if I need gum treatment, I will not insist that I simply get a cleaning (prophylaxis).
7. **Extractions and Surgery**
I understand that all dental extractions or surgeries carry risks. Some are minor like a dry socket following an extraction. Some are life-threatening such as post-surgical infection or anaphylaxis.
8. **Fee for Additional or Specialty Care**
I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for what insurance does not cover.
9. **Limitations of Insurance Coverage**
There are charges beyond what insurance will pay, e.g., composite fillings instead of amalgam (silver) fillings, temporary dentures, tapping off crowns or bridges, bleaching or cosmetic work. Also, as a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what the insurance does not cover.

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10. **48 Hour Notice for Cancellation**
    I agree to give 24-hour notice for cancellations or pay the broken appointment fee of $160.00. I understand that leaving a message after the office closed the day (or weekend) before is not sufficient notice.
11. **Requesting Record Transfers**
    Professional Courtesies are between dentists. I agree not to request records until I have a new dentist.
12. **Dental Appointments**
    If I am more than 15 minutes late for my dental appointment, I will either take my remaining time only or reschedule and pay a broken appointment fee.

I hereby acknowledge that no guarantees, warranties, or assurance can be given with treatment and that it will be completely successful in function or appearance (to my complete satisfaction). It is anticipated that treatment will work but because of the uniqueness of each individual and every case and because the practice of dentistry is not an exact science, long-term success can't be promised.

I have read the above and consent to treatment. I hereby acknowledge that I have read this document and have had the opportunity to ask any questions about anything that I do not fully understand.

______________________________ ________________ ______________________________

Patient/Parent or Guardian Signature   Date   Witness Signature

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MEDICAL HISTORY

PATIENT NAME ______________________________ DOB _____________________________

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?	**Yes/No**	If yes, please explain: _________________
Have you ever been hospitalized or had a major operation?	**Yes/No**	If yes, please explain: _________________
Have you ever had a serious head or neck injury?	**Yes/No**	If yes, please explain: _________________
Are you taking any medications, pills, or drugs?	**Yes/No**	If yes, please explain: _________________
Do you take, or have you taken, Phen-Fen or Redux?	**Yes/No**	If yes, please explain: ________________
Are you on a special diet?	**Yes/No**	If yes, please explain: ________________
Do you use tobacco?	**Yes/No**	If yes, please explain: ________________
Do you use controlled substances?	**Yes/No**	If yes, please explain: ________________
Do you need to pre-medicate?	**Yes/No**	If yes, please explain: ________________

Women only: Are you Pregnant/Trying to get pregnant? Yes/No
Taking oral contraceptives: Yes/No Nursing? Yes/No

Are you allergic to any of the following? (Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please list: ____

Do you have, or have you had, any of the following? (Circle)

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Renal Dialysis
Alzheimer's Disease	Diabetes	Hepatitis A	Rheumatic Fever
Anaphylaxis	Drug Addiction	Hepatitis B or C	Rheumatism
Anemia	Easily Winded	Herpes	Scarlet Fever
Angina	Emphysema	High Blood Pressure	Shingles
Arthritis/Gout	Epilepsy or Seizures	Hives or Rash	Sickle Cell Disease
Artificial Heart Valve	Excessive Bleeding	Hypoglycemia	Sinus Trouble
Artificial Joint	Excessive Thirst	Irregular Heartbeat	Spina Bifida

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Asthma	Fainting Spells/Dizziness	Kidney Problems	Stomach/Intestinal
Blood Disease	Frequent Cough	Leukemia	Stroke
Blood Transfusion	Frequent Diarrhea	Liver Disease	Swelling of Limbs
Breathing Problem	Frequent Headaches	Low Blood Pressure	Thyroid Disease
Bruise Easily	Genital Herpes	Lung Disease	Tonsillitis
Cancer	Glaucoma	Mitral Valve Prolapse	Tuberculosis
Chemotherapy	Hay Fever	Pain in Jaw Joints	Tumors or Growths
Chest Pains	Heart Attack/Failure	Parathyroid Disease	Ulcers
Cold Sores/Fever Blist.	Heart Murmur	Psychiatric Care	Venereal Disease
Heart Pacemaker	Radiation Treatments	Yellow Jaundice	Convulsions
Heart Trouble/Disease	Recent Weight Loss	Congenital Heart Disorder	

Have you ever had any serious illness not listed above? If yes, please list:
____
____

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 ___________________________
DATE ____________________

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DENTAL HISTORY

PATIENT NAME: ___________________________________ DATE:______________________

1. REASON FOR VISIT: ____
2. DATE OF LAST DENTAL TREATMENT: ____
3. ARE YOU HAVING PAIN AT THIS TIME? YES/NO
4. HAVE YOU EVER HAD:
   - ORTHODONTIC TREATMENT? YES/NO
   - ORAL SURGERY? YES/NO
   - PERIODONTAL TREATMENT? YES/NO
   - YOUR TEETH GROUND OR BITE ADJUSTED? YES/NO
   - A BITE PLATE, DENTURES OR OTHER APPLIANCE? YES/NO
5. HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH? YES/NO
6. DO YOU SUFFER FROM PAIN AND/OR SWELLING OF YOUR GUMS? YES/NO
7. DO YOUR GUMS OFTEN BLEED WHEN YOU BRUSH YOUR TEETH? YES/NO
8. PROBLEMS OF THE JAW. HAVE YOU EVER EXPERIENCED:
   - CLICKING OF THE JAW? YES/NO
   - PAIN (JOINT, EAR, SIDE OF FACE)? YES/NO
   - DIFFICULTY IN OPENING AND CLOSING? YES/NO
   - DIFFICULTY IN SPEAKING? CHEWING? SWALLOWING? YES/NO
   - CHANGES IN THE WAY YOU BITE? YES/NO
9. HABITS—DO YOU:
   - CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? YES/NO
   - BITE YOUR LIPS OR CHEECKS REGULARLY? YES/NO
   - HOLD FOREIGN OBJECTS WITH YOUR TEETH? (SUCH AS: PENCILS, PIPE, PINS, NAILS, BITE FINGERNAILS?) YES/NO
10. DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT? YES/NO
11. BREATHING ISSUES:
    - DO YOU HAVE BREATHING PROBLEMS? YES/NO
    - DO YOU HAVE INTERRUPTED SLEEP PATTERNS? YES/NO
    - DO YOU SNORE DURING SLEEP? YES/NO
12. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? YES/NO
    IF NO, PLEASE EXPLAIN WHAT YOU WOULD LIKE TO CHANGE ABOUT THE APPEARANCE OF YOUR TEETH: ____
    ____

PATIENT SIGNATURE: ______________________________ DATE:__________________

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FINANCIAL AGREEMENT

Thank you for choosing DaVinci Dentistry as your dental provider. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

• You must provide us with an insurance card and all the information necessary to verify you and/or your dependents' coverage and file your claim.

• Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.

• You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.

• Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely **YOUR** responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.

• All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

PAYMENT POLICY

• We accept cash, personal checks, debit cards, AMEX, Visa, MasterCard and Discover.

• After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.

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• If the insurance company does not pay in full within 30 days, it will be your responsibility to pay the balance due within two weeks.

• We do not file claims for medical insurance or more than one dental insurance company per patient.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A **$25.00** charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finances charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVERDUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 48 hours' notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to additional fees. Broken appointments prevent others from receiving the dental care they deserve.

We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

Initials: ____________

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FEE FOR MISSED APPOINTMENT IF 48-HOUR NOTICE NOT GIVEN: To reschedule or cancel an appointment, you must notify us at lease forty-eight (48) hours in advance to avoid a missed appointment fee of **$160.00.** We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

Initials: ___________

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your record or radiographs for a nominal duplication fee.

CONSENT & AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of DaVinci Dentistry. Without any reservations, I agree to abide by the policies outlined herein.

Patient Name: ____ Date: ____________

Signature: ______________________________________

Relationship to patient: ____

If not patient, are you the person legally responsible for this patient? Yes/No (Circle One)

Reviewed by staff member: ________________________ Date: ________________

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name: ____

Patient phone number Cel.: ____________________ Home: ______________________

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

1. Detailed description of the information to be released (i.e. x-rays, clinical notes, treatment plans, appointments, etc.)

2. To whom may the information be released (i.e., spouse, children, legal guardian, etc.):
   Name: __________________________________ Relationship: ______________
   Name: __________________________________ Relationship: ______________
   Name: __________________________________ Relationship: ______________

3. Expiration date or event relating to the individual or purpose for the release (i.e., one year, indefinitely, etc.):
   ____

It is completely your decision whether to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state, or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated________________ Patient Signature_________________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient ___________ Print Name ____________________________
Source of Authority (self, parent, or legal guardian) _________________________

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CONSENT TO LEAVE MESSAGE

I give my consent to DaVinci Dentistry PA doctors and staff to leave a detailed message regarding scheduling, treatment, surgery, medicine information, or other information as necessary (check all that apply)

___________ on an answering machine or voicemail
___________ at home or cell phone

___________ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly.

Patient's Name (Please Print) ________________________ DOB: ______________

Patient's Signature _______________________________ Date: _____________

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PHOTOGRAPHY CONSENT FORM/MODEL RELEASE/MEDIA RELEASE

I, (print name)____, hereby grant permission to DaVinci Dentistry, its employees, representatives, or affiliates to take and use; photographs/digital images, videotape, audio recording or quoted remarks, educational or other PowerPoint or presentation materials of me and/or my children, for use in our social media (such as Facebook or Twitter) or educational materials. These materials might include printed or electronic publications, Web sites or other electronic communications. I further agree that my name and/or children names and identity may be revealed in descriptive text or commentary in connection with the image(s).
I authorize the use of these materials indefinitely without compensation to me. All negatives, positives, prints, digital reproductions and video and audio recordings shall be the property of Davinci Dentistry.

____
(Date)

____
(Signature of adult subject)