

Welcome

ABOUT YOU

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ Male Female
Last First MI Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ Single Married Divorced Widowed Separated

Home Address: _____

Home Phone #: (____) _____ Cell #: (____) _____ Work Phone #: (____) _____ Ext: _____ Driver License #: _____
Street City State Zip

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (____) _____ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Drivers License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Drivers License #: _____

INSURANCE INFORMATION

Primary Insurance Dental Coverage? Yes No Medical Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? Yes No Medical Coverage? Yes No Orthodontic Coverage? Yes No

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

DENTAL HISTORY

Why have you come to the dentist today? _____

- Are you currently in pain? Yes No
- Do you require antibiotics before dental treatment? Yes No
- Have you experienced problems associated with any previous dental work? Yes No
- Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No
- Your current dental health is Good Fair Poor
- Do you floss daily? Yes No Brush daily? Yes No
- Type of bristles on your toothbrush? Hard Medium Soft
- How long do you use a toothbrush before replacing it? _____
- Do you use anything in addition to your brush and floss? Yes No
- If yes, what? _____
- Would you like fresher breath? Yes No Whiter teeth? Yes No

- Do your gums ever bleed? Yes No Ever Itch? Yes No
- Have you ever had periodontal disease? Yes No
- Do you have mobility in your teeth? Yes No
- Are your teeth sensitive to heat, cold, or anything else? _____
- Do you still have wisdom teeth? Yes No
- If yes, why? _____
- Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)
- Why did you leave your previous dentist? _____
- What did you like most & least about any dentist you have seen? _____
- Are you happy with the way your smile looks?** Yes No
- If not, what would you change? _____

MEDICAL HISTORY

- Do you have a personal physician? Yes No Date of last visit: _____
- Physician's Name: _____
- Address: _____ Phone #: (____) _____
- Your current physical health is:** Good Fair Poor
- Are you currently under the care of a physician? Yes No
- Please explain: _____
- Do you smoke or use tobacco in any other form? Yes No
- Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? Yes No
- Have you ever taken Fosamax, or any other Bisphosphonate? Yes No

- Are you allergic to any of the following?**
- | | | |
|------------------------|----------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Sedatives |
| Y N Barbiturates | Y N Jewelry / Metals | Y N Sulfa Drugs |
| Y N Codeine | Y N Latex | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Penicillin | Y N Other |
- Please list additional drugs/materials that cause allergic reactions: _____

- For Women:** Are you taking birth control pills? Yes No
- Are you pregnant? Unsure Yes No
- Week #: _____ Are you nursing? Yes No

Are you taking any of the following?

- | | | | |
|--------------------|--------------------------------|----------------------------|----------------------|
| Y N Acetaminophen | Y N Blood Thinners | Y N Insulin/Diabetes Drugs | Y N Thyroid Medicine |
| Y N Antibiotics | Y N Blood Pressure Medication | Y N Nitroglycerin | Y N Tranquilizers |
| Y N Antihistamines | Y N Cold Remedies | Y N Recreational Drugs | |
| Y N Aspirin | Y N Digitalis/Heart Medication | Y N Steroids/Cortisone | |

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? Yes No If yes, please list each one: _____

Do you or have you experienced the following?

- | | | | | |
|-----------------------------|-----------------------------|---------------------------------|----------------------------------|-------------------------|
| Y N Abnormal Bleeding | Y N Colitis | Y N Headaches | Y N Liver Disease | Y N Seizures |
| Y N Alcohol Abuse | Y N Congenital Heart Defect | Y N Heart Attack | Y N Low Blood Pressure | Y N Shingles |
| Y N Anemia | Y N Diabetes | Y N Heart Murmur | Y N Lupus | Y N Sickle Cell Disease |
| Y N Arthritis | Y N Difficulty Breathing | Y N Heart Surgery | Y N Mitral Valve Prolapse | Y N Sinus Problems |
| Y N Artificial Bones/Joints | Y N Drug Abuse | Y N Hemophilia | Y N Osteoporosis/Paget's Disease | Y N Steroid Therapy |
| Y N Artificial Valves | Y N Emphysema | Y N Hepatitis | Y N Pacemaker | Y N Stroke |
| Y N Asthma | Y N Epilepsy | Y N Herpes | Y N Persistent Cough | Y N Thyroid Problems |
| Y N Blood Transfusion | Y N Fainting Spells | Y N High Blood Pressure | Y N Psychiatric Treatment | Y N Tonsillitis |
| Y N Cancer | Y N Fever Blisters | Y N HIV+/AIDS | Y N Radiation Treatment | Y N Tuberculosis (TB) |
| Y N Chemotherapy | Y N Glaucoma | Y N Hospitalized for Any Reason | Y N Rheumatic Fever | Y N Ulcers |
| Y N Chicken Pox | Y N Hay Fever | Y N Kidney Problems | Y N Scarlet Fever | Y N Venereal Disease |

Please list any serious medical condition(s) that you have experienced: _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____.

Signature _____ Date _____

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____ Date _____

Cancellation Policy

In order to respect your reserved appointment(s) and our daily schedule, our office policy regarding appointments (that have been reserved especially for you) is as follows: anyone who cancels an appointment less than 48 hours in advance, fails to appear, or is more than 30 minutes late will be charged \$75 cancellation fee.

We understand things come up and patients need to reschedule. We only ask that you understand there are many patients to be seen and calling in advance to reschedule will help us reach those patients who would like to be seen.

X

Hugh W. Oser DDS PA

1135 Keller Pkwy | Keller TX, 76248 | (817) 431-5514

Written Financial Policy

Thank you for choosing Hugh W. Oser, DDS, PA. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

We offer a courtesy accounting adjustment to patients who pay **ONE WEEK PRIOR TO TREATMENT for treatment plans of \$350 or more**. If payment is made by credit card, we offer a 2% savings, if by cash or check; we offer a 5% savings.

- NO INTEREST¹ Payment Plans² from Care Credit

- Allow you to pay over time with NO INTEREST¹
- Convenient, low monthly payment plans² also available
- No annual fees or pre-payment penalties

Please note:

Hugh W. Oser, DDS, PA requires payment prior to the completion of your treatment.

For Oral Sedation and Oral Surgery, payment in full is required to secure your initial treatment appointment. There is a fee of \$360.00 for Oral Sedation, non-refundable, and not covered by any insurance company.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. **However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. Patient portions are estimated based on information supplied by your insurance carrier and are not guaranteed to be exact, therefore, any amount not covered by your insurance is your responsibility.**

Hugh W. Oser, DDS, PA charges \$20 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

APPENDIX I – Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication Consent Form

Patient Name:	Date of Birth:
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This consent form allows the Organization to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

The Organization has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at the Organization.

Initial I hereby authorize the Organization to use unsecured email and mobile phone text messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; and, 2) Information related to billing and payment.

Initial I hereby authorize that the Organization may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

Email
 Home Phone
 Office Phone
 Cell Phone

Initial I hereby authorize that the Organization may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

Initial I hereby authorize that the Organization may disclose my personal health information to the person who I have listed as my emergency contact.

Initial I hereby authorize that the Organization may disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that the Organization services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that the Organization may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while the Organization is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient	Date:
Signature of Parent (if minor) / Authorized Representative	Date: