Treaty Oak Dental PLLC Patient Information and Health History

Patient Name: Last: _____ First: _____ Middle Int: _____

Birthdate: _____ Sex: **M** **F** Soc Sec #: _____ Driver's License #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____ Referred By: _____

MEDICAL HISTORY IMPORTANT INFORMATION NEEDED:

Do you have any current health problems? **Y** **N** If YES explain: _____
Have you ever had a joint replacement? **Y** **N** If YES explain: _____
Are YOU required to take an antibiotic prophylaxis due to any medical conditions? **Y** **N** If YES explain: _____
_____
Have you ever had a serious head or neck injury? **Y** **N** If YES explain: _____
Have you ever or currently take Phen-Fen / Redux **Y** **N**
Please list ALL medications you currently take? _____
_____
Have you ever taken any Bisphosphonate medications of? Fosamax, Boniva, Actonel, Atelvia, Didronel NONE
Are you pregnant? **Y** **N** Tobacco use? **Y** **N** Do you use any controlled substance? **Y** **N** _____
Are you allergic to any of the following? Aspirin, Penicillin, Clindamycin, Ibuprofen, Codeine, Latex, Metal, Tylenol
Sulfa Drugs, Local Anesthetics, Other: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING PLEASE MARK ALL THAT APPLY

_ AIDS/HIV Positive
_ Alzheimer's Disease
_ Anaphylaxis
_ Anemia
_ Angina
_ Arthritis/Gout
_ Artificial Heart Valve
_ Artificial Joint
_ Asthma
_ Blood Disease
_ Breathing Problems
_ Bruise Easily
_ Cancer
_ Chemotherapy
_ Chest Pains
_ Cold Sores/Fever Blisters
_ Congenital Heart Disorder
_ Convulsions
_ Diabetes
_ Drug Addiction
_ Emphysema
_ Epilepsy or Seizures
_ Excessive Bleeding
_ Excessive Thirst
_ Fainting Spells/Dizziness
_ Frequent Cough
_ Frequent Headaches
_ Glaucoma
_ Hay Fever
_ Heart Attack/Failure
_ Heart Murmur
_ Heart Pacemaker
_ Heart Trouble/Disease
_ Hemophilia
_ Hepatitis A
_ Hepatitis B or C
_ High Blood Pressure
_ High Cholesterol
_ Hives or Rash
_ Hypoglycemia
_ Irregular Heartbeat
_ Kidney Problems
_ Leukemia
_ Liver Disease
_ Low Blood Pressure
_ Lung Disease
_ Mitral Valve Prolapse
_ Oral Cancer
_ Osteoporosis
_ Pain in Jaw Joints
_ Psychiatric Care
_ Radiation Treatment
_ Renal Dialysis
_ Rheumatic Fever
_ Rheumatoid Arthritis
_ Scarlet Fever
_ Shingles
_ Sinus Trouble
_ Stomach/Intestinal Disease
_ Stroke
_ Thyroid Disease
_ Tuberculosis
_ Tumors or Growths
_NONE

Any other illness / condition no listed above: _____

Signature: _____ **Date:** _____

Treaty Oak Dental PLLC
Bruce W. Jay D.D.S.
OFFICE FINANCIAL POLICY & DENTAL INSURANCE INFORMATION

It is the policy of Treaty Oak Dental PLLC, Bruce W. Jay D.D.S. that payment is due in full at the time services are rendered. Please talk with our office manager if financial arrangements need to be made prior to your scheduled appointment. We require all patients pay their deductible, copay, and or coinsurance at the beginning of each visit.

As a courtesy, Treaty Oak Dental PLLC, Bruce W. Jay D.D.S. will verify your dental insurance with your carrier, please provide us with your dental insurance information below. A quote of benefits is not a guarantee of payment by your dental insurance. Your claim will be processed according to your plan, if your claim processes differently from the benefits given by your insurance, you are responsible for the procedures not covered by your carrier. Our office will be happy to help file the claim for you.

Should your account become delinquent due to faulted plan, all parties associated will be turned over to a collections agency with an additional fee of $25. Full payment is required for services provided on all future visits.

Printed Name: _____

Signature: _____

Date: _____

DENTAL INSURANCE INFORMATION

Employer Name: _____

Insured's Name: _____ Birthdate: _____ SS#: _____

Dental Insurance Carrier Name: _____

Address: _____ Phone Number: _____

Member/Subscriber ID#: _____ Group Number: _____

NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM

Treaty Oak Dental PLLC, Bruce W. Jay D.D.S.

The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the receptionist. Review the policy carefully and let us know if you have any questions or requests.

By my signature below, I acknowledge that I have received the Notice of Health Information Practices of ***Treaty Oak Dental PLLC, Bruce W. Jay D.D.S***. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____

Name of Patient

_____

Signature of Patient

_____

Date