Patient Information

Patient Last Name
-

Patient First Name
-

Patient MI
-

(Preferred Name)
-

Date:
-

Gender:
-

Marital Status:
-

Social Security #:
-

Birth Date:
-

Phone (Home):
-

(Work):
-

Ext:
-

Best time to call:
-

Cell:
-

Email Address:
-

Street Address:
-

Apartment #
-

City
-

State
-

ZIP Code
-

Spouse or Responsible Party Information

The following is for:

☐ the patient's spouse ☐ the person responsible for payment

Name:
-

-

-

Social Security #:
-

Birth Date:
-

Phone (Home):
-

(Work):
-

Ext:
-

Driver's License
-

Street Address
-

Apartment #
-

City
-

State
-

Zip Code
-

Employment Information

The following is for:

☐ the patient ☐ the person responsible for payment

Employer Name:
-

Occupation:
-

Street Adress
-

City
-

State
-

Phone
-

Insurance Information

Primary

Name of Insured: (Last, First, MI)
-

Is insured a patient?
-

Insured's Birth Date:
-

ID #:
-

Group #:
-

Insured's Address: (Street, City, State, Zip Code)
-

Insured's Employer Name:
-

Address: (Street, City, State, Zip Code)
-

Patient's relationship to insured:
-

Other
-

Insurance Plan Name and Address:
-

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in full at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian (ESign)

Date :

Relationship to Patient:
-

Signature of guarantor of payment/responsible party (ESign)

Date :

Relationship to Patient:
-

Broad Park Health History Form

Patient First Name
-

Patient Last Name
-

Gender
-

DOB:
-

Race/Ethnicity:
-

General Health History

Do you have any of the following conditions: (Select all that apply)

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Autism
- ☐ Mental Health Problems
- ☐ Thyroid Condition
- ☐ Cancer
- ☐ Hayfever/Seasonal Allergies
- ☐ Chronic Sinusitis/ Sinus Congestion
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Difficulty Swallowing
- ☐ Acid Reflux/ Heartburn
- ☐ Stomach Ulcers
- ☐ Irritable Bowel Syndrome
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure/ Hypertension
- ☐ Heart Rhythm Abnormalities
- ☐ Cardiac Pacemaker
- ☐ Heart Valve Replacement
- ☐ Heart Disease
- ☐ History of Heart Attack
- ☐ History of Stroke
- ☐ Blood Clotting Problems
- ☐ Blood Disorders
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Fever Blisters/ Herpes
- ☐ Aids/ HIV Infection
- ☐ Tuberculosis
- ☐ Other Contagious Disease
- ☐ Kidney/ Bladder Trouble
- ☐ Sexual Problems
- ☐ Dry Mouth/ Dry Eyes
- ☐ Gum (periodontal) Disease
- ☐ Fainting Spells/ Seizures
- ☐ Epilepsy
- ☐ Joint Replacement
- ☐ Trauma/ Injury to Face
- ☐ Tinnitus (Ringing in the ears)
- ☐ TMJ Pain
- ☐ Fibromyalgia/ Chronic Body Pain
- ☐ Chronic Neck Pain

Headaches

Do you have chronic headaches?

-

If yes, how often
-

What triggers the headache?
-

What relieves headache?
-

Describe headache:

- ☐ Dull
- ☐ Thunderclap
- ☐ Aching
- ☐ Sharp

What part of the head?

- ☐ Forehead
- ☐ Behind eyes
- ☐ One Side only
- ☐ Sides of the head
- ☐ Top of the Head

Allergies

Are you allergic to any of the following?

- ☐ Latex
- ☐ Metal
- ☐ Acrylics
- ☐ Contrast Dye
- ☐ Pain Medications
- ☐ Plastic
- ☐ Food
- ☐ Antibiotics

List all allergies (including those to medications):

-

Sleep Health History

Do you have any of the following conditions: (Select all that apply)

- ☐ Snoring
- ☐ Central Sleep Apnea
- ☐ Insomnia
- ☐ Restless Leg Syndrome
- ☐ Sleep Walking
- ☐ Night Terrors
- ☐ Obstructive Sleep Apnea
- ☐ Excessive Daytime Sleepiness
- ☐ Narcolepsy
- ☐ Periodic Limb Movement
- ☐ Bed Wetting
- ☐ Circadian Rhythm Disorder

Have you currently or previously used any of the following treatments for OSA?

Mandibular Advancement Device
- ☐ Current
- ☐ Past

Hypoglossal nerve stimulation (INSPIRE)
- ☐ Current
- ☐ Past

CPAP
- ☐ Current
- ☐ Past

Myofunctional Therapy
- ☐ Current
- ☐ Past

Airway Surgery
- ☐ Past

Tongue Tie Release (frenectomy)
- ☐ Past

Care Providers

Do you have a Primary Care Provider (including Pediatrician)?

If yes, name?
-

Do you have a Sleep Specialist or ENT?

If yes, name?
-

Medication

Do you take any of the following medication types at least once a week?

- ☐ Blood pressure medication
- ☐ Pills for diabetes
- ☐ Depression medication
- ☐ ADHD medication/stimulants
- ☐ Sexual function stimulant
- ☐ Thyroid medication
- ☐ Antihistamine or steroid for nasal congestion
- ☐ Chemotherapy agents (IV or oral)
- ☐ Sleeping medication
- ☐ Insulin
- ☐ Pain medication
- ☐ Anxiety medication
- ☐ Bladder urge suppressant
- ☐ Cannabinoids (THC or CBD)
- ☐ Home Oxygen
- ☐ Bisphosphonates

List any medications taken (prescriptions, OTC, herbal supplements):

-

Are you required to Pre-med with antibiotics before dental treatment?

-

Surgeries/Hospitalizations

Have you had any surgery on the following body parts or types?

- [ ] Nose
- [ ] Tongue
- [ ] Palate/Lips
- [ ] Back (spine)
- [ ] Sleep Apnea
- [ ] Weight Loss Surgery
- [ ] Sinus
- [ ] Jaw
- [ ] Tonsils/Throat
- [ ] Adenoids Removed
- [ ] Neck
- [ ] Lungs
- [ ] Brain
- [ ] TMJ
- [ ] Teeth

List ALL previous surgeries or procedures below {include year}:

Are you planning on any upcoming surgeries or procedures?
-

Details:
-

Have you been hospitalized within the past 5 years?
-

If yes, what illness or problem?
-

Patient Dental History

When was your last dental visit?
-

Date of last radiographs (x-rays):
-

How many dentists have you seen in the last 5 years?
-

What is your immediate dental need?
-

Rate your smile from 1-10 (1= Dissatisfied, 10 happy)
-

What aspect of your smile would most like to correct?
-

Has anything prevented you from addressing this concern in the past?
-

Does dental treatment make you nervous?
-

Have you ever had your teeth whitened in the past, including over-the-counter products?
-

If Yes, please explain:
-

Do you have any of the following?

- [ ] Bleeding gums
- [ ] Loose teeth
- [ ] Sensitivity to cold
- [ ] Sensitivity to heat
- [ ] Burning tongue/lips
- [ ] Swelling or lumps in the mouth
- [ ] Frequent blisters on lip/mouth
- [ ] Sensitivity to sweets
- [ ] Food impactions
- [ ] Sensitivity to pressure
- [ ] Bite your cheeks/lips
- [ ] Difficulty opening or closing jaw
- [ ] Clicking/popping in the jaw
- [ ] Clenching or grinding
- [ ] Change in bite or multiple bites
- [ ] Shifting teeth
- [ ] Orthodontic treatment
- [ ] Unpleasant taste/bad breath
- [ ] Gum recession
- [ ] Gum disease
- [ ] Teeth removed for braces
- [ ] Wisdom teeth removed
- [ ] Change in teeth shape/length

Other:
-

How often do you brush?
-

Your toothbrush is:
-

Dental & Orthodontics

Are you planning on any upcoming dental work?
-

Details of upcoming dental work:
-

Are you currently undergoing any orthodontic treatment?
-

Name of orthodontist or specialist
-

Have you undergone orthodontics in the past (i.e. braces, aligners, expanders, etc.)?
-

If Yes: How many times?
-

Have you ever had IPR (slimming teeth in ortho)?
-

Have you ever had headgear?
-

Were permanent teeth removed as part of your orthodontics
-

Family & Social

Family History (Select all that Apply)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Snoring
- ☐ Insomnia
- ☐ Anxiety
- ☐ Heart Disease
- ☐ Obesity
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Restless Leg Syndrome
- ☐ Depression

Family History Details:
-

Are you a current or former smoker?
-

How many packs per week?
-

Do you consume alcohol?
-

How many drinks per week?
-

Do you regularly consume caffeine or sugary drinks?
-

Type of caffeine/sugary drink and how often?
-

WOMEN ONLY-Are you pregnant or planning to become pregnant?
-

Are you currently breastfeeding?
-

Sleep Questionnaire

Have you ever had a sleep test administered?
-

If yes, when did you have your last sleep test?
-

Have you been diagnosed with Sleep Apnea?
-

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea?
-

Are you happy with your CPAP or Sleep Appliance?
-

If you are not happy, why?
-

How often do you get out of bed to use the restroom during the night?
-

Do you usually wake up feeling tired or unrested?
-

Do you habitually snore?
-

Have you been diagnosed with Hypertension/High Blood Pressure?
-

Do you often Suffer from waking headaches?
-

Do you regularly experience daytime drowsiness or fatigue?
-

Do you have blocked nasal passages?
-

Has anyone observed you stop breathing in your sleep?
-

Do you ever wake up choking or gasping?
-

Do you grind your teeth while you are sleeping?
-

Is your neck circumference greater than 40 cm / 15.75 in?
-

Calculate your BMI Weight times 703 divided by height in inches and then divided by height in inches again. What is your BMI?
-

Financial Policy

Payment Options

☐ Cash

☐ Check

☐ Major Credit Cards - Visa, Mastercard, American Express, and Discover

☐ Patient Payment Plans through; Care Credit- No interest or Extended payment plans, which our office can give you more information regarding these.

Patient's without Dental Insurance

Our office policy requires that payment is due in full on the date of service.

Patient's with Dental Insurance

We would like to highlight a MISCONCEPTION- dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payment. All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by Premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care! The treatment recommended by our office is never based on what your insurance company will pay. Your health and treatment should not be governed by an insurance contract. We will file your insurance as a courtesy to you, but we do expect your estimated payment and necessary deductible to be paid at the time of service. The estimated co-payment is merely an estimate and not a guarantee of payment by your insurance company. It should also be understood, that the dental insurance contract is between the patient and the insurance company. The patient bears the ultimate financial responsibility.

We hope you find this information helpful. Please take the time to view your contract thoroughly so we may better serve you. As always, feel free to ask any questions for clarification on services, billing and insurance

**There will be a $25.00 charge on all returned checks.
****There will also be a $50.00 charge per hour on appointments that are not cancelled 48 hours prior to appointment.**

Significant costs are incurred in carrying our patient's accounts. To control these costs and help keep fees down, it is necessary to adhere to this financial policy.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to my dental care. I hereby authorize payment of my dental benefits to Broad Park Family Dentistry.

Signature (ESign)

First Name
-

Middle Name
-

Date :

Last Name
-

PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT FORM FOR PATIENT

Broad Park Family Dentistry
1750 East Broad
Mansfield, Texas 76063

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but it is not mandatory for me to sign in order to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third-party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bonded to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have taken action relying on this consent.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I authorize Broad Park Family Dentistry to leave messages at the phone numbers I have provided, which may include answering machines and/or voice mails regarding upcoming appointments.

DOB
-

PATIENT FIRST NAME
-

PATIENT MIDDLE NAME
-

PATIENT LAST NAME
-

SIGNATURE (ESign)

Date :

RELATIONSHIP TO PATIENT
-