Welcome to Independence Dental!

We are honored that you have chosen us as your dental care provider.
Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.
Please take a few moments to complete the following information, so we can better care for you.

Patient Information:

Patient Name: _____Preferred Name:_____
Birth Date: _____Male: _____ Female: ____ Married: _____ Single: _____ Minor: Y N
SS#: _____Driver's License#_____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Work #: _____Cell#_____
E-mail address: _____ Best way to reach you _____
Employer: _____
Emergency Contact: _____Relation_____ Phone #: _____
How did you hear about us? _____
If referred by someone, whom may we thank for the referral? _____
Previous /Present Dentist_____ Phone#_____ Date of Last Visit_____
Physician's Name: _____ Phone#_____ Address: _____

Parent/Guardian Information (if patient is a minor):

Name: _____ Relationship to patient: _____
Birth Date: _____ SS#: _____ Driver's License #: _____
Address: _____ City: _____State: _____ Zip: _____
Home Phone #: _____ Work #: _____ Cell #_____

Dental Insurance Information (Primary):

Policyholder's Name: _____Birth Date: _____ SS#: _____
Insurance Company: _____ Group #: _____
Employer: _____ Policyholder's ID#: _____
Patient Relationship to Policyholder: Self___ Spouse____ Child____ Other_____

Dental Insurance Information (Secondary):

Policyholder's Name: _____Birth Date: _____ SS#: _____
Insurance Company: _____ Group #: _____
Employer: _____ Policyholder's ID#: _____
Patient Relationship to Policyholder: Self___ Spouse____ Child____ Other_____

Important Patient Information

If any you have any questions, don't hesitate to ask our staff member.

1. **Insurance policy:** I request that all benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be assign directly to the dentist. I understand that I am responsible for all charges whether or not paid by insurance. We will assist you to maximize your insurance benefits, and we will file claims to your insurance carrier that offers the assignment of benefits, if you desire. We will estimate your available benefit amount, however, we cannot guarantee that your insurance will pay. If benefits not received within 60 days from your insurance company, the entire balance becomes patient's responsibility. I authorize to release pertinent medical information to my insurance company when requested, or to facilitate process of clam.

2. **Financial Responsibility:** estimated out-of-pocket payments are due at the time of service unless other arrangements have been made. In the event payments are not received by the agreed upon date, I understand that a 1% finance charge (12% APR) may be added to my account, in addition to any collection charges. We charge $35 billing charge for any statement sent 90 days after charges were incurred.

3. **Diagnostic X-rays:** I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnosis aids in order to complete a thorough diagnosis and treatment plan. I understand that all diagnostic x-rays are the property of the doctors, but copies available upon request for a fee.

4. **Medical Status Update:** I have answered all the questions about me or my dependent's medical history and present health truthfully. I also understand, if any changes in health status, that it is my responsibility to inform the doctor at the next appointment.

5. **Cancellation Policy:** If you find that you cannot commit to your reserved appointment, we ask you to provide a minimum cancellation notice of 48 hours. Failure to do so will result in minimum missed appointment fee of $50.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Patient Name: _____Date of Birth: _____

Parent/Guardian Name: _____Relationship:_____

Signature: _____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Independence Dental
3100 Independence Pkwy, Suite 204
Plano, TX 75075

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. 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've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations 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 take action in reliance thereon. I have received the "Notice of Privacy Practices" and have been provided an opportunity to review it. Copy of Notice of Privacy Practice is available on request.

I request the following restrictions to the use or disclosure of my health information:

Patient full name: _____

Date of birth: __/__/_____

Parent/ Guardian: _____

Signature: _____

Date: __/__/_____

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No

If yes, please list: _____

Do you use or smoke tobacco in any form? ☐ Yes ☐ No

Have you or do you take Redux/Fen Phen or Pondimin? ☐ Yes ☐ No

For women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No week# _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+/AIDS
Y	N	Angina Pectoris	Y	N	Hospitalized Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Latex Allergy
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusions	Y	N	Low Blood Pressure
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Nervous/Anxious
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack	Y	N	Tumors
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Heart Surgery	Y	N	Venereal Disease
Y	N	Hemophilia	Y	N	Yellow Jaundice
Y	N	Hepatitis			

Do you have, or have you had any disease, condition, or problem not listed above?:

_____

_____

Are you allergic to any of the following items?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other

Please list any other drugs you are allergic to:

Dental History

Why have you come to the dentist today? _____

_____

Are your teeth sensitive to: ☐ Heat ☐ Cold ☐ Pressure ☐ Sweets

Do you have any fear of dental work? ☐ Yes ☐ No

What work was done at your last dental office visit? _____

_____

How do you feel about the appearance of your teeth? _____

_____

How would you describe the condition of your teeth and gums?

☐ Good ☐ Fair ☐ Poor

Are you currently in pain or discomfort with your teeth or gums?

☐ Yes ☐ No If yes, please explain: _____

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? ☐ Yes ☐ No

Do your gums bleed when you floss? ☐ Yes ☐ No

Have you ever experienced pain in you jaw joint? ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms? ☐ Yes ☐ No

If yes, please explain: _____

Do you grind or clench your teeth? ☐ Yes ☐ No

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____

Date: _____

Warranty Certificate

We stand behind all our work and offer you as six month warranty on all dental work, so you can have peace of mind that if anything were to happen, we will fix it at no cost. We also offer an extended warranty up to five years at no extra charge with the following simple requirements below.

Treatment	Warranty	Patient's Responsibility/Simple Requirements
Crowns and Bridges **5 Years Warranty**	Any fracture with normal use, we will replace or repair them at no additional charge.	**1.Keep up with your recommended periodic exam, x-rays and cleaning appointments. This allows us to monitor and maintain your dental work.** 2. Have all recommended dental treatments performed by our dental office, including treatment of jaw occlusal dysfunction and use of night guard if recommended. 3. This warranty does not include anything not mentioned here, including recurrent decay, fracture of tooth structure, root canal therapy, night guards, nor does it cover damages caused by accidents, trauma, neglect or improper use (e.g., chewing ice or biting non-food items). 4. Other terms and restrictions may apply.
Composite Fillings and Porcelain Veneers **2 Years Warranty**	Any fracture with normal use, we will replace or repair them at no additional charge. When the tooth is fractured to the point that a crown is indicated, we will credit the cost of the filling towards the cost of a crown.	
Permanent Partials **5 Years Warranty**	Any fracture with normal use, we will replaced or repair them at no additional cost.	

This warranty is null and void if the patient does not maintain their 6-month continuing care cleaning appointments with Independence Dental.

I acknowledge that I have read and understood the requirements that I must satisfy in order to qualify for the extended warranty provided at Independence Dental.

Patient's Signature_____Date:_____

Doctor's Signature: _____Date:_____