PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Patient's Name _____ Sex M F Birth Date _____ Age _____
Mailing Address _____ City _____ State _____ Zip _____
Marital Status S M D W Social Security # _____ Email _____
Home Phone _____ Cell# _____ Work# _____
Employer: _____ Person Responsible for Account: _____ Phone: _____
Referred By _____ Emergency Conact _____ Phone _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Do you drink Alcohol?
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke? ❑ yes ❑ no

Do you use chewing tobacco? ☐ yes ☐ no

Are you *ALLERGIC* to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other: _____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (Blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Osteoporosis (bone density) medicine

PLEASE LIST CURRENT MEDICATIONS:

_____
_____
_____
_____
_____

Women:

- ❑ Pregnant or could be Pregnant
  Expected delivery date: _____
- ❑ Taking Birth Control or hormones? _____

Do you have any other disease, condition, or problem not listed above? _____

Last Dental Exam _____ Have you had any complications during dental treatment? _____

Do you need to pre-medicate with antibiotics before dental treatment? _____

Pain or clicking in Jaw? _____ History of Dental Surgery or injury to face or jaw? _____

Have you been hospitalized or had a major operation? _____

Current Physician's Name _____ Phone: _____

Have you evern taken Fosamax, Boniva,Actonel or other bisphosphonates? _____ When? _____

Signature of Patient/Guardian _____ Date _____

Signature of Doctor: _____ Date _____

Dr. Stacie J. Test, DDS
400 Bolivar Suite #302 Sanger, Texas 76266

HIPAA Acknowledgement of Privacy Practices and Disclosures of Information

Name of Patient: _____ Date of Birth: _____

*I have received or denied a copy of the Notice of Privacy Practices for HIPAA Compliance Information which is included in the New Patient Paperwork provided by Dr. Stacie J. Test, D.D.S., P.A.

_____ _____
Signature of Patient/Legal Guardian Date

*I hereby authorize the dental providers and personnel of Stacie J. Test, D.D.S., P.C. to discuss my protected dental/medical health information with:

_____ _____
Name Relationship

_____ _____
Name Relationship

Photography Release

*I hereby authorize Dr. Stacie Test or her assistants to take photographs of my mouth, face, jaws, and teeth. I understand that these are records of my oral care and will be kept confidential.

_____
Signature of Patient/Guardian

*In the event that my photos are able to be used for any publication as part of a demonstration such as Dr. Test's website, Facebook, or other publication, I give my permission for her to use them understanding that my name will be kept confidential and no compensation will be given. (This is optional)

_____ _____
Signature of Patient/Guardian Date

Stacie J. Test, DDS
400 Bolivar Ste #302
Sanger, TX 76266

DENTAL TREATMENT AGREEMENT FORM

Patient Name:_____ **Date:**_____

1. Health Information

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

2. 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.

3. Needle Stick

If someone is inadvertently stuck with a needle used on me, I consent to have blood drawn for analysis.

4. Fillings, Crowns, and Un-anticipated Root Canals

Some teeth may need a root canal even after a simple filling, fillings and crowns to take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.

5. Root Canals can Fail

Root Canals can fail and may require additional treatment or I may end up having the tooth extracted.

6. 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 can not be changed.

7. 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).**

8. 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.

9. 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 understand I am financially responsible for full the full balances whether I have insurance or not.**

10. Limitations of Insurance Coverage

There are charges beyond what insurance will pay, e.g. nitrous oxide, temporary dentures, tapping off crowns, bridges or bleaching or cosmetic work. Also, as a service to patients, this office will file insurance claims on your behalf. I understand that what may be quoted, as my portion (co-payment) is only an estimate. **I understand I am financially responsible for my full balance whether or not I have Insurance.**

11. 24 Hour Notice for Cancellation

I agree to give 24-hour notice for cancellations or pay the broken appointment fee. I understand that leaving a message after the office is closed the (or weekend) day before is NOT sufficient notice.

12. Requesting Record Transfers

Professional courtesies are between dentists. I agree not to request records until I have a new dentist.

13. Hygiene Appointments

If I am more than 15 minutes late for my cleaning appointment, I will either take my remaining time only or Reschedule and pay a broken appointment fees. A shorter appointment my cause the patient to need to come back for a second visit.

I do not expect guarantees in dental care. I have read the above and consent to treatment.

Signature of Patient or Parent of Minor Witness (Office Staff)

Stacie J. Test DDS

OFFICE FINANCIAL POLICY

Thank you for choosing the office of Dr. Stacie Test for your dental health. New patients are always appreciated. The growth of our practice is a direct result of referrals from our patients and referring doctors. As our patient please feel free at any time to express any concerns or to ask any questions that you may have.

Our primary mission is to deliver the best and most comprehensive dental care available. Please understand and agree that payment for the care provided is the responsibility of the patient or responsible party named.

If you do not have insurance payment is due in full at the time of service unless otherwise arranged prior to appointment.

If you do have insurance we estimate your co-pay based on the information provided by you and your insurance company at the time of service. **The co-pay you are quoted is an ESTIMATE only, if a balance remains after insurance has paid the claims submitted, the remaining balance is yours to pay.**

If we are unable to verify benefits at the time of your appointment, payment is expected in full. As a courtesy, our office will file all claims for you and reimbursement will come directly to you.

The amount of coverage paid by your insurance company may be based on a fee schedule. We have no control over the fee schedule pricing, updates, etc. We estimate your co-pay based on the information we have at the time of verification. Insurance companies may "downgrade" procedures at the time of claim review. These decisions are at the discretion of the insurance company. Our office is not made aware of these downgrades until we receive the EOB Estimation of Benefits after the appointment has been completed. Dr. Test only performs composite (tooth colored) fillings, many insurance companies will downgrade this type of filling on molars. **The amount that the insurance company disallows on any procedure will be your responsibility.** If your insurance company has not paid within 30 days of your appointment, you will receive a statement and payment will be due from you. We strive to provide your insurance company with any information they need to process claims within this time frame.

There is a $35 charge on all returned checks.

Accounts that go beyond 60 days past due will be accessed a finance charge of 1.5% per month on the unpaid balance unless previous arrangements have been made.

Accounts that go beyond 90 days past due without contacting our office to make payment arrangements will be turned over to a collection agent. A fee of 30% of the balance total will be added to the account if turned over a collection agency to cover filing fees.

If you No Show on a confirmed appointment there will be a $50.00 charge added to your account. If a patient cancels more than 2 times in a calendar year without 24 hour notice there will be a $35.00 charge added to your account.

I understand that the fee estimates on my treatment plan are extended for **90 days** from the date of consultation, after 90 days an updated treatment plan will be provided showing any treatment and/or fee changes.

_____ Date _____

Patient, Parent or Guardian Signature