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 Contact _____ Phone _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

- ❑ Cancer or tumor: _____
- ❑ Heart condition _____
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial Joint or heart valve? Year: _____
- ❑ High or low blood pressure _____
- ❑ Pacemaker year: _____
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease _____
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic or Emotional condition _____
- ❑ Epilepsy, seizures, or fainting spells _____
- ❑ Arthritis
- ❑ Cold sores/Mouth ulcers/Oral Herpes sores _____
- ❑ AIDS or HIV positive
- ❑ STD _____
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Allergies or sinus trouble
- ❑ Asthma

Do you smoke? ❑ yes ❑ no

Do you use chewing tobacco? ❑ yes ❑ no

ANY OTHER CONDITIONS NOT LISTED?

_____

_____

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 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? _____

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

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

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

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: _____ Pharmacy Name: _____

Signature of Patient/Guardian _____ Date _____

Doctor's Signature _____ Date _____

Karen Avantino, DDS
400 Bolivar Suite #302 Sanger, Texas 76266
HIPAA Acknowledgement of Privacy Practices and Disclosures of Information

PATIENT NAME: _____

I hereby give the office of Karen Avantino, DDS permission to discuss my protected dental/medical health information with the following people:

_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #

*I have seen or received 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.

x_____ _____

Signature of Patient/Legal Guardian Date

1. May we send you a text message reminder for your appointments? Yes or No
2. May we send you Email reminders for your appointments? Yes or No

Karen Avantino, DDS

Office Financial Policy

PATIENT NAME: _____

Thank you for choosing the office of Dr. Karen Avantino your dental health. New patients are always appreciated. The growth of our practice is a direct result of referrals from our patients from our patients and referring doctors. As our patient, please feel free to express any concerns or 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. Insurance is filed as a courtesy to our patients and the balance is the patient's responsibility.

If you do not have insurance, payment is due in full at the time of service.

If you do have dental insurance, we will estimate your co-pay based on the information provided. The co-pay that 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. Also, 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 you will be reimbursed.

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 or Estimation of Benefits after the appointment has been completed. We only use top grade materials and we will not compromise the level of care to our patients because of insurance downgrades. For example, Dr. Test only performs composite (tooth colored) fillings. Many insurances will downgrade this type of filling giving the allowance for an amalgam (silver mercury) filling. The amount that they insurance company disallows on any procedure will be your responsibility. If your insurance 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 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 to a collection agency to cover filling fees.

****If you NO SHOW for a confirmed appointment there will be a $50 no show fee added to your account. If a patient cancels more than once a year without a 24-hour notice, you will be subject to a $50 charge added to your account.**

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

X_____ _____

Patient, Parent or Guardian Signature **DATE**

Karen Avantino, DDS
Dental Treatment Agreement Form

Patient Name: _____

1. Health Information

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

3. **Needle Stick**

If someone is inadvertently stuck with a needle that was previously 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 needed 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

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 that the color cannot be changed.

7. Gum Treatment and requesting "Just a Cleaning"

I may have a deteriorating gum condition. Sometimes these are due to smoking, not flossing, or are inherited. I may have gum or periodontal disease. A regular cleaning will not sufficiently clean my teeth and I will not insist that I simply get a cleaning.

8. Extractions and Surgery

I understand that all dental extractions or surgeries carry risks. Some are minor like a dry socket. Some are life threatening such a post-surgical infection or anaphylaxis.

9. Fee for Additional or Specialty Care

I understand that I may need treatment beyond what was originally planned. I may be referred to a specialist for additional care. I understand that I am financially responsible for the full balance whether I have insurance or not.

10. Limitations of Insurance Coverage

I understand that occasionally there are charges beyond what insurance will pay, e.g., laughing gas, temporary dentures, bleaching, or cosmetic work and that is my responsibility. Insurance is filled as a courtesy and I am financially responsible for my full balance whether insurance pays or not.

11. 24 Hour Notice for Cancellation

I agree to give 24-hour notice for cancellations or I will be subject to a fee and that leaving a message on the answering machine during non-office hours is not sufficient notice.

12. 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 fee. A shorter appointment may cause the patient in need to come back for a second visit.

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

_____ _____

Signature of Patient or Parent/Guardian **DATE**