Patient Information

Patient Name: _____ Date: _____
Last First MI

Name that you go by informally: _____

☐ Male ☐ Female ☐ under 18yo ☐ Single ☐ Married ☐ Partnered ☐ Other _____

Social Security #: _____ Driver License #/ State _____ _____ Birth Date: _____

Phone (Cell): _____ (Work): _____ Ext: _____ (Home): _____

eMail: _____ (Email is for office use only will not be shared or sold)

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency contact person: _____ Phone: _____ Relationship to Patient _____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
  ☐ Heart Murmur
  ☐ Mitral valve Prolapse
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
  Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

LIST MEDICATIONS:
_____
_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

How did you hear about our office? ☐Another patient _____

☐ Advertisement (name of publication): _____ ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Cell): _____ (Work): _____ Ext: _____ (Home): _____

eMail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services on Following Page

Patient Name _____ **Date** _____

1. What's most important to you about your visit today? _____

2 When was the last time you had your teeth cleaned, examined or had an oral cancer exam? _____

3. What was the last type of dental treatment you had? _____

4. How long would you like to keep your natural teeth? _____

5. Please rank your concerns in order of importance 1-3

   _____ My budget _____ My appearance _____ My current pain

6. When we discuss treatment with you, would you like for us to focus on:

   (Circle one) what is possible only what is necessary

7. Let's talk for a minute about your home care:
   - Do your gums ever bleed? Y N
   - When? _____
   - Do you floss regularly Y N
   - How often? _____
   - Does food get caught in any spaces between your teeth? Y N
   - If yes, would you like to correct your spaces? Y N
   - Do any of your teeth hurt today? Y N
   - Where? _____

8. Ok, now let's talk about your current condition:
   - Do you have a partial or full denture now? Y N
   - If yes, when was it made? _____
   - Are you happy with it? Y N
   - Do you have missing teeth? Y N
   - Where? _____
   - Would you like to replace them so you can chew more easily? Y N
   - Do you have popping or clicking in your jaws when you chew? Y N
   - Headaches or migraine? Y N
   - Do you smoke or use smokeless tobacco product? Y N
   - If yes, how long, how much, how often _____
   - Are you nervous about treatment?
   - Has fear kept you from coming to the dentist in the past? Y N

   • If yes, explain possible relaxation methods we can use to reduce anxiety.

9. Lastly, let's talk about your smile and appearance:
   - Are you happy with your smile ... right now? Y N
   - If there were anything you could change about your smile, what would it be? _____
   - Would you like us to give you more information about improving your smile today? Y N

Doctor _____ TX Coordinator _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance of your treatment. This 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.

_____ (initial) All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash 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.

A service charge of 1½% per month (18% per year on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

_____ (initial) I understand that the fee estimate listed for this dental care can only be extended for a period of one month from the date of the patient examination. Fees are subject to change without notice.

_____ (initial) I agree to pay at the time dental services are rendered to me. I understand that I am responsible for paying my portion before insurance (if I am insured) or the total for treatment if I am uninsured, either by cash, credit card or financial carrier. I further agree that I will pay any portion of my treatment not covered by insurance, for whatever reason.

Should I owe outstanding funds to this office and have not made payment arrangements within 90 days, I agree to pay all collection fees, court costs and reasonable attorney fees generated in collecting my outstanding balance.

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

Name: _____

Date: _____

Relationship to Patient: _____

Signature of patient, parent or guardian: _____

OUR POLICY OF CARE AND PAYMENT

Payment is due at the time of treatment. We accept cash, check, and major credit cards. We also have a payment plan called **Care Credit**, which allows you to start treatment today and spread payments over time.

Payment Options

1. Cash or Check
2. Major Credit Cards
3. Care Credit

Applying for Care Credit only takes a few minutes and there is no fee to apply.

Please indicate below the form of payment you choose to settle your account: check one

- ☐ Cash or Check
- ☐ Major Credit Card
- ☐ Care Credit (Subject to credit Approval) If credit application is declined, another form of payment listed above is required.

_____ _____

Signature of Patient/Responsible Party Date

William N. Castle, D.D.S., PLLC

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies
(Adult)

I have received a copy of the Notice of Privacy Practices of William N. Castle, D.D.S., PLLC. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____
Print Name Address

_____ _____
Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

4. _____ Date Added / Removed: _____

5. _____ Date Added / Removed: _____

* * *

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____

PATIENT CONSENT

Clinical

1. I authorize William N. Castle, D.D.S., PLLC to perform all recommended treatment.

2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

5. A $50 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

Insurance

6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.

7. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____

Patient's Address: _____