

**Medical History**

PATIENT NAME: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

Are you under a physician's care now? <input type="radio"/> Yes <input type="radio"/> No Physicians name _____ Have you ever been hospitalized or had a major operation? <input type="radio"/> Yes <input type="radio"/> No Have you ever had a serious head or neck injury? <input type="radio"/> Yes <input type="radio"/> No Are you taking any medications, pills, or drugs? <input type="radio"/> Yes <input type="radio"/> No Do you take, or have you taken, Phen-Fen or Redux? <input type="radio"/> Yes <input type="radio"/> No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? <input type="radio"/> Yes <input type="radio"/> No Are you on a special diet? <input type="radio"/> Yes <input type="radio"/> No Do you use tobacco? <input type="radio"/> Yes <input type="radio"/> No Do you use controlled substances? <input type="radio"/> Yes <input type="radio"/> No	If yes, please explain: _____ Physicians number _____ If yes, please explain: _____ If yes, please explain: _____ If yes, please explain: _____ _____ If yes, please explain: _____ If yes, please explain: _____ If yes, please explain: _____
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Women: Are you

Pregnant/Trying to get pregnant?  Yes  No      Taking oral contraceptives?  Yes  No      Nursing?  Yes  No

Are you allergic to any of the following? \_\_\_\_\_

Aspirin    Penicillin    Codeine    Local Anesthetics    Acrylic    Metal    Latex    Sulfa Drug

None    Other   If yes, please explain: \_\_\_\_\_

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No Anemia <input type="radio"/> Yes <input type="radio"/> No Angina <input type="radio"/> Yes <input type="radio"/> No Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No Artificial Joint <input type="radio"/> Yes <input type="radio"/> No Asthma <input type="radio"/> Yes <input type="radio"/> No Blood Disease <input type="radio"/> Yes <input type="radio"/> No Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No Breathing Problem <input type="radio"/> Yes <input type="radio"/> No Bruise Easily <input type="radio"/> Yes <input type="radio"/> No Cancer <input type="radio"/> Yes <input type="radio"/> No Chemotherapy <input type="radio"/> Yes <input type="radio"/> No Chest Pains <input type="radio"/> Yes <input type="radio"/> No Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No Congenital Heart Disease <input type="radio"/> Yes <input type="radio"/> No Convulsion <input type="radio"/> Yes <input type="radio"/> No	Cortisone medicine <input type="radio"/> Yes <input type="radio"/> No Diabetes <input type="radio"/> Yes <input type="radio"/> No Drug Addiction <input type="radio"/> Yes <input type="radio"/> No Easily Winded <input type="radio"/> Yes <input type="radio"/> No Emphysema <input type="radio"/> Yes <input type="radio"/> No Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No Frequent Cough <input type="radio"/> Yes <input type="radio"/> No Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No Genital Herpes <input type="radio"/> Yes <input type="radio"/> No Glaucoma <input type="radio"/> Yes <input type="radio"/> No Hay Fever <input type="radio"/> Yes <input type="radio"/> No Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No Heart Murmur <input type="radio"/> Yes <input type="radio"/> No Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No Hepatitis A <input type="radio"/> Yes <input type="radio"/> No Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No Herpes <input type="radio"/> Yes <input type="radio"/> No High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No High Cholesterol <input type="radio"/> Yes <input type="radio"/> No Hives or Rash <input type="radio"/> Yes <input type="radio"/> No Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No Kidney Problems <input type="radio"/> Yes <input type="radio"/> No Leukemia <input type="radio"/> Yes <input type="radio"/> No Liver Disease <input type="radio"/> Yes <input type="radio"/> No Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No Lung Disease <input type="radio"/> Yes <input type="radio"/> No Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No Osteoporosis <input type="radio"/> Yes <input type="radio"/> No Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No
		Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No Rheumatism <input type="radio"/> Yes <input type="radio"/> No Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No Shingles <input type="radio"/> Yes <input type="radio"/> No Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No Spina Bifida <input type="radio"/> Yes <input type="radio"/> No Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No Stroke <input type="radio"/> Yes <input type="radio"/> No Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No Tonsillitis <input type="radio"/> Yes <input type="radio"/> No Tuberculosis <input type="radio"/> Yes <input type="radio"/> No Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No Ulcers <input type="radio"/> Yes <input type="radio"/> No Venereal Disease <input type="radio"/> Yes <input type="radio"/> No Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  Yes  No    If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_



## Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt# \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Sex: Male \_\_\_ Female \_\_\_ Marital Status: Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed \_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ DL# \_\_\_\_\_  
E-mail: \_\_\_\_\_  would like to receive correspondences via e-mail.  
Employment Status:  Full Time  Part Time  Retired Student Status:  Full Time  Part Time  
Emergency Contact- Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medicaid ID#: \_\_\_\_\_ Chip ID# \_\_\_\_\_

### Responsible Party (if different)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt# \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Sex: Male \_\_\_ Female \_\_\_ Marital Status: Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed \_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ DL# \_\_\_\_\_

### Primary Insurance Info:

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
Insured Soc. Sec. \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
Employer \_\_\_\_\_ Ins. Company \_\_\_\_\_  
Ins. Mailing Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
ID# \_\_\_\_\_ Group# \_\_\_\_\_

### Secondary Insurance Info:

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
Insured Soc. Sec. \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
Employer \_\_\_\_\_ Ins. Company \_\_\_\_\_  
Ins. Mailing Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
ID# \_\_\_\_\_ Group# \_\_\_\_\_



## Notice of Privacy Practices

The increasing demand for access to medical information by providers and others, such as insurance companies, has led to increasing concern about patient privacy and confidentiality, leading to the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This act requires providers, and others who maintain health information, to implement security measures to guard the integrity and confidentiality of patient information.

Trinity Dental Care utilizes your health information for treatment and to obtain payment for treatment. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

I understand that I may refuse to sign this authorization and that I may revoke it at any time but I must do so in writing to Trinity Dental Care, 2500 NE Green Oaks, Suite 102, Arlington, TX 76006. The revocation will not be effective to the extent that information has already been disclosed. I understand that the persons to whom information is disclosed to under this authorization may possibly re-disclose the information to others without my knowledge or consent and, therefore, law may no longer protect the privacy of my personal and health information.

I authorize Trinity Dental Care to release my medical records or insurance information as necessary to process my dental claims and coordinate or manage my care.

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Relationship of Personal Representative(if any)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



Welcome to Trinity Dental Care

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

How did you hear about us?

- Existing Patient: \_\_\_\_\_
- Out Door Sign
- Flyer Delivered to your home
- Employee Referral \_\_\_\_\_
- Insurance Referral \_\_\_\_\_
- Amazon
- Groupon
- Phone book
- Door hanger
- Search engine
- 1-800 Dentist
- Star Telegram
- Other \_\_\_\_\_

Como escuchaste de nosotros?

- Pateinte reciente: \_\_\_\_\_
- Anuncio afuera
- Anuncio recibido por correo
- Referido por empleado \_\_\_\_\_
- Referido por aseguranza \_\_\_\_\_
- Amazon
- Groupon
- Libro divectorio
- Anuncio en su puerta
- Buscado por computadora (internet)
- 1-800 Dentist
- Star Telegram
- Otra manera \_\_\_\_\_



*In an effort to keep cost down while maintaining a high level of professional care, we have established the following policy for our patients. We encourage you to discuss any questions you may have regarding our policy.*

#### **FINANCIAL POLICY**

1. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE.
2. PAYMENT MAY BE MADE BY CASH, CHECK, CREDIT CARD, or UPON PRIOR CREDIT APPROVAL FROM SELECT FINANCIAL INSTITUTIONS.

Account balances over 30 days old may be subject to a billing charge of no more than \$25 per month and/or a finance charge at a rate of 1.5% (Annual Percentage Rate 18%). To avoid these charges, you may pay the account balance before the 30<sup>th</sup> day. My account balance includes insurance benefits for which Trinity Dental Care has filed a claim.

#### **INSURANCE**

If you have dental insurance, we will assist you in determining all benefits available. **Your insurance policy is a contract between you and the insurance company;** therefore, we cannot guarantee payment of any claims or accept the responsibility of negotiating with insurance companies or other persons. If any insurance company pays only a portion of the bill or rejects your claim, **you are responsible for full payment for services rendered.** Conversely, if your insurance company pays above the projected estimation, you will receive a credit in that amount which may be withdrawn as a refund or applied to further treatment.

We will allow 90 days for the insurance to pay on estimated amounts from your primary insurance coverage. After 90 days, **THE BALANCE IS DUE IN FULL.** If you have secondary coverage we can file your insurance for you; however, any portion not paid is your responsibility. Please bring a **COMPLETED INSURANCE CLAIM FORM** with you on each visit, if your company requires their own form. A fee may apply.

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**Signature**

**Date**



# HIPAA Release of Information Authorization Form

I, \_\_\_\_\_ hereby authorize Trinity Dental Care and its affiliates, it's Employee's and agents, to release my personal health information (e.g. **information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, member ID number** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

Please list the party(s) you wish to share your information with.

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for coverage of services

Name of member: \_\_\_\_\_

Signature of Member: \_\_\_\_\_

Date: \_\_\_\_\_

If applicable, legal representatives sign below:

*By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof(e.g. Power of Attorney, Living Will, Guardianship papers,etc.) that I am legally authorized to act on the members behalf with respect to this authorization form.*

Name of legal representative: \_\_\_\_\_

Signature of legal representative: \_\_\_\_\_

Date: \_\_\_\_\_

Name of whiteness: \_\_\_\_\_

Signature of whiteness: \_\_\_\_\_