Trinity FAMILY DENTAL 817.283.3801

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?	◯Yes	◯No	If yes, please explain:_____
Physicians name _____			**Physicians number** _____
Have you ever been hospitalized or had a major operation?	◯Yes	◯No	If yes, please explain:_____
Have you ever had a serious head or neck injury?	◯Yes	◯No	If yes, please explain:_____
Are you taking any medications, pills, or drugs?	◯Yes	◯No	If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux?	◯Yes	◯No	If yes, please explain:_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯Yes	◯No	_____
Are you on a special diet?	◯Yes	◯No	If yes, please explain:_____
Do you use tobacco?	◯Yes	◯No	If yes, please explain:_____
Do you use controlled substances?	◯Yes	◯No	If yes, please explain:_____

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

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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#_____

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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 Family Dental 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 Family Dental, 800 N. Industrial Blvd Ste. 103 Euless, TX 76039. 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 Family Dental 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

_____ Date:_____/_____/_____

Relationship of Personal Representative(if any)

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Welcome to Trinity Family Dental

How did you hear about us?

☐ Existing Patient: _____ ☐

☐ Out Door Sign ☐

☐ Employee Referral_____ ☐

☐ Insurance Referral _____ ☐

☐ Phone book ☐

☐ Search engine ☐

☐ Other _____ ☐

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 30th day. My account balance includes insurance benefits for which Trinity Family Dental 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.

Signature **Date**

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HIPAA Release of Information
Authorization Form

I, _____ hereby authorize Trinity Family Dental 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 witness: _____

Signature of witness: _____