ADULT PATIENT HISTORY

Date:________/________/________ Date of Birth:________/________/________ Age: ________

Patient's Name: [Last]________________ [First]________________ [MI] ________

Marital Status:________________ Male/Female:________________

Social Security #________-________-________ Driver's License #________________ State: ________

Home Address:________________________ Apt. no. ________

City:________________ State:________ ZIP:________-________

Home Telephone: (______) ________-________ Cell Telephone: (______) ________-________

Email address: ________________________

Patient Employed By:________________________

Business Address: ________________________

City:________________ State:________ ZIP:________-________

Business Telephone: (______) ________________ Ext: (______) Occupation: ________

Spouse's Name: [Last]________________ [First]________________ [MI] ________

Spouse's Telephone: (______) ________-________ Cell Telephone: (______) ________-________

Business Address: ________________________

City:________________ State:________ ZIP:________-________

Purpose of visit?________________ Referred by: ________________

Emergency Contact________________ Telephone: (______)________-________ Relationship to Patient ________

Will you be using Dental Insurance? YES (___) / NO (___)

RESPONSIBLE PARTY INFORMATION (If different from above)

Responsible Party's Name: [Last]________________ [First] ________________

Relationship to Patient:________________ Date of Birth: ________/________/________

Social Security #________-________-________ Driver's License #________________ State: ________

Home Address:________________________ Apt. no. ________

City:________________ State:________ ZIP:________-________

Home Telephone: (______) ________-________ Cell Telephone: (______) ________-________

Employer: ________________________

Business Address: ________________________

City:________________ State:________ ZIP:________-________

Business Telephone: (______) ________-________ Ext: (______)

MEDICAL HISTORY (Circle any of the following which you have had, or have.)

High Blood Pressure		Rheumatic fever		Epilepsy		Convulsions		Thyroid problems	
Fainting/seizures		Asthma		Kidney diseases		AIDS/HIV		Radiation treatment	
Heart attack or disease		Diabetes		Angina		Frequently tired		Blood transfusion	
Cardiac pacemaker		Stroke		Arthritis		Joint replacement		Drug addiction	
Heart murmur		Cancer		Liver disease		Ulcers		Alcoholism	
Mitral valve prolapsed		Hepatitis A		Glaucoma		Hay fever		Fever blisters	
Hemophilia		Hepatitis B		Chemotherapy		Allergies or hives		Weight loss	
Bleeding problems		Hepatitis C		Anemia		Psychiatric treatment		Tobacco Use	
Sexually transmitted diseases		Nervousness		Anorexia		Tuberculosis		Osteoporosis	
Persistent cough (longer than three weeks)		Jaundice		Swollen ankles		Low blood pressure		Latex Allergy	

Remarks

ADULT PATIENT HISTORY

	PERSONAL MEDICAL HISTORY	Yes	No
1	Are you now under the care of a physician?		
Physician's name & phone			
2	Are you on pain management?		
Physician's name & phone			
3	Have you been hospitalized for a surgical procedure or serious illness in the last 5 years?		
If yes, please explain:			
4	Are you taking any medications, prescription or over-the-counter?		
Please list:			
5	Do you have special needs due to any medical or handicapping condition? Please explain;		
6	Are you allergic to any medications? If yes, please list:		
7	Women: Are you pregnant? If yes how far? Please list information in #1.		
8	Do you have an allergy to latex?		

	PERSONAL DENTAL HISTORY	Yes	No
1	Are you nervous about dental treatment?		
2	Do your gums bleed while brushing or flossing?		
3	Are your teeth sensitive to: Hot [ ] Cold [ ] Sweet [ ] Foods [ ] Liquids [ ] Air [ ]		
4	Do you feel pain in any of your teeth?		
5	Do you have any sores, or lumps, in your mouth?		
6	Have you had any head, neck or jaw injuries?		
7	Have you ever experienced any of these in your jaw;		
	Clicking [ ], Pain [ ], Difficulty Opening [ ], Difficulty Closing [ ], Difficulty Chewing [ ]		
8	Do you have frequent headaches?		
9	Do you clench or grind your teeth?		
10	Do you bite your lips or cheeks frequently?		
11	Have you ever experienced any difficult extractions in the past?		
12	Any prolonged bleeding after extractions?		
13	Have you had any orthodontic treatment?		
14	Do you wear dentures or partials? If yes, date of placement: ______/______/______		
15	Have you received oral hygiene instructions regarding the care of your teeth & gums?		
16	Do you like your smile?		
Date of your last dental examination ______/______/______			

AUTHORIZATION and RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of my treatment or examination rendered to me or an adult dependent during the period of dental care to a third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I understand I am financially responsible for all charges whether or not paid by insurance.
Payment is due in full at the time of treatment unless prior arrangements have been approved.

Signature ______________________ Date ______________________

INFORMED CONSENT

The undersigned hereby authorizes the Dentist/Staff to provide these diagnostic and preventative services: dental x-rays, teeth cleaning, dental examination. I also authorize treatment as indicated and understand that use of anesthetic agents embodies a certain risk.

Signature ______________________ Date ______________________

EDDIE G. TENNISON, D.D.S.

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All patients must complete our "Patient Information Form" before seeing the doctor.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

- WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, AMERICAN EXPRESS, DISCOVER.

ADULT PATIENTS
Adult patients are responsible for **full payment** at time of service.

MINORS ACCOMPANIED BY AN ADULT
The adult accompanying a minor, and his/her parents (or guardians), are responsible for **full payment** at the time of service.

UNACCOMPANIED MINORS
The parents (or guardians) are responsible for **full payment**. Non-emergency treatment will be denied unless charges have been paid in full at time of service.

REGARDING INSURANCE
If you have insurance, we will help you receive maximum benefits.

We MAY accept your insurance if you obtain approval from our office staff prior to the date of service. If we accept your insurance, you must pay your estimated portion. If your insurance company has not paid the FULL BALANCE within 45 days, you have 15 days to pay the balance. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We are NOT a party to this contract, in most cases. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

MISSED APPOINTMENTS
Unless canceled 24 hours in advance, our policy is to charge for missed appointments at the rate of $15 per 15 minutes of appointment time.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature ______________________________ Date ______________

Eddie G. Tennison D.D.S.
2117 N. Mays
Round Rock, TX 78664
(512) 244-1221

APPOINTMENT POLICY
PLEASE READ AND SIGN

We are happy to provide services for your child. However we are unable to provide for patients who do not keep scheduled appointments. It generally takes our staff 48 hours at least to fill a cancelled appointment. Patients who call to reschedule appointments with at least two days notice can usually be accommodated without a problem. Short notice cancellations and patients who "no show" appointments may result in permanent discontinuation of services. This is a private dental office and we simply cannot afford to provide for folks who do not take their appointments seriously. We do make exceptions in situations of unavoidable circumstances (like traffic accidents and sudden serious illness). However appointments broken without at least 24 hours notice will almost always result in a broken appointment fee or discontinuation. Please understand that we must keep the doctor and hygienist completely scheduled at all times. We are not a government funded clinic and must generate a profit to pay our employees and stay in business. Your cooperation in this matter is greatly appreciated.

In general it is our policy to confirm all appointments 48 hours in advance. If we leave a message at your residence or job, please <u>Do</u> return our phone call to confirm or change the appointment. If the office staff does not answer when you call, there is an answering machine at 244-1221 to leave a message. If we do not hear from you by the day before the scheduled appointment, <u>we will attempt to give your appointment to another patient.</u> It may be difficult for you to reschedule without a substantial delay. We want to work with you if you have problems keeping a scheduled appointment. But we need reasonable notice to change appointments and you <u>have to</u> call. Please give us all your phone numbers including cell phone and pager if you have them. We need to reach you during our business hours. Remember that we don't mind if you break an appointment. We just want to know in advance so that we can keep our schedule full.

____
Signature

Eddie G. Tennison, DDS
2021 North Mays, Ste 1200
Round Rock, TX 78664
Phone: (512) 244-1221

Acknowledgement of Receipt of Notice of Privacy Practices

I, ________________________________ have received a copy of the
(Name of Patient)

Notice of Privacy Practices for Eddie Tennison, DDS.

____
(Signature of Patient or Responsible Party)

Staff Will Fill Out This Section If Patient's Signature Is Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our notice of Privacy Practices, but it could not be obtained for the following reason:

____ Patient refused to sign.

____ Emergency situation kept us from obtaining the Patient's signature

____ Language barriers kept us from obtaining the Patient's signature.

____ Other ________________________________

Eddie G. Tennison, DDS
2021 N Mays St, Ste 1200
Round Rock, Texas 78664

Medical Information Release Form

(HIPAA Release Form)

Name: ______________________________ **Date of Birth:** _____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse______________________________

[ ] Child(ren)______________________________

[ ] Other______________________________

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:______________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ______________________________

The best time to reach me is (*day*)______________ between (*time*)__________

Signed: ______________________________ Date: ____/____/_____

Witness:______________________________ Date: ____/____/_____