PATIENT MEDICAL HISTORY

Date: _____________
Date of your last dental visit? ______________

Patient Name: ____
Address: ____
City, State, Zip: ___________________________ E-mail: ____
Home: ________________ Cell: ________________ Birthday: _____________ S.S. # _______________
Marital Status: Married, Divorced, Single, Widowed
Primary Dental Guarantor: ___________________ Secondary Dental Guarantor: ___________________
Physician Name: _________________________ Physician Phone: _______________________________
Pharmacy: _______________________________ Pharmacy Phone: _______________________________
Who may we thank for referring you to our office? ____

Sex: Male/ Female (If female, please answer the following)
__ Y __ N Are you taking birth control pills?
__ Y __ N Are you pregnant? (If yes # of weeks ______)
__ Y __ N Are you nursing?
Please answer the following?
__ Y __ N Do you smoke or use tobacco?
__ Y __ N Do you use Alcohol products? (If yes, how much?) ___________________________________
__ Y __ N Do you have Sleep Apnea? (If yes, do you wear a CPAP / Oral Appliances?) ______________

Conditions

__ Y __ N Abnormal bleeding
__ Y __ N Alcohol Abuse
__ Y __ N Allergies
__ Y __ N Anemia
__ Y __ N Angina Pectoris
__ Y __ N Arthritis
__ Y __ N Artificial bones
__ Y __ N Artificial heart valve
__ Y __ N Asthma
__ Y __ N Atrial Fibrillation
__ Y __ N Blood transfusion
__ Y __ N Blood thinner
__ Y __ N Botox/Dermal fillers
__ Y __ N Cancer
Explain:_____________________
__ Y __ N Chemotherapy
__ Y __ N Colitis
__ Y __ N Congenital heart defect
__ Y __ N Congestive heart failure
__ Y __ N Cosmetic Surgery

__ Y __ N COPD
__ Y __ N Diabetes
__ Y __ N Difficulty breathing
__ Y __ N Drug Abuse
__ Y __ N Emphysema
__ Y __ N Epilepsy
__ Y __ N Fainting spells
__ Y __ N Fever Blisters
__ Y __ N Frequent Headaches
__ Y __ N Glaucoma
__ Y __ N Hay fever
__ Y __ N Heart attack
__ Y __ N Heart Surgery
__ Y __ N Hemophilia
__ Y __ N Hepatitis type: ______
__ Y __ N High blood pressure
__ Y __ N HIV/Aids
__ Y __ N Joint replacement
__ Y __ N Kidney problems
__ Y __ N Liver disease

__ Y __ N Low blood pressure
__ Y __ N Mitral Valve Prolapse
__ Y __ N Pace Maker
__ Y __ N Pneumonia
__ Y __ N Psychiatric problems
__ Y __ N Radiation Therapy
__ Y __ N Rheumatic Therapy
__ Y __ N Seizures
__ Y __ N Shingles
__ Y __ N Sickle Cell Disease
__ Y __ N Sinus Problems
__ Y __ N Stroke
__ Y __ N Thyroid problems
__ Y __ N Tuberculosis
__ Y __ N Ulcers
__ Y __ N Venereal Disease
__ Y __ N Vertigo
__ Y __ N Yellow Jaundice
Other: ____________________

HAVE OR HAVE YOU EVER HAD ANY HOSPITALIZATION FOR ILLNESS OR INJURY? Y__ N __

____

Do you have or have ever had an ALLERGIC reaction to:

- Ibuprofen
- Acetaminophen
- Codeine
- Penicillin
- Adhesives
- Latex
- Erythromycin
- Tetracycline
- Sulfa
- Metals (nickel, gold, silver)
- Fluoride
- Local Anesthetic
- Other: ____________

CONTINUE ON BACK SIDE

Describe any current medical treatment, impending treatment/operations or any other medical or dental information that may possibly affect your current dental condition or treatment: ____

____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose
_________________________	_______________________________
_________________________	_______________________________
_________________________	_______________________________
_________________________	_______________________________
_________________________	_______________________________
_________________________	_______________________________
_________________________	_______________________________
_________________________	_______________________________

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature: ____ Date: ____________________

Doctors Signature: ____ Date: ____________________

7825 Hwy 6 N Ste 109

Houston, TX 77095

Office Number: 281-463-3538

Fax Number: 281-463-3730

Dental Insurance Information

Primary Dental Insurance:

Name of Insured: ______ ______ ______
Last First MI

Insured Birth Date: ______ ID/SS # ______ Group # ______

Insured Address if different ______
Street Address
______ ______ ______
City State Zip Code

Insured's Employer Name: ______

Patient's relationship to insured: O Self O Spouse O Child O Other

Insurance Plan Name: ______

Insurance Plan Phone: ______

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 Copperfield Dentistry. I hereby authorize, as indicated by my signature below, Copperfield Dentistry to use and disclose my protected health information to 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 on home telephone number: _____________________________________
You may contact me at on mobile telephone number: ____________________________________
You may contact me at on 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: ________________

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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: ________

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any 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 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I have read and understand the HIPAA policy.
In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

Signature of patient, parent, or guardian (responsible party):

Signature: ____ Date: _______________________

Relationship to Patient: [ ]

OFFICE POLICIES

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our OFFICE POLICIES. If you have any questions, please ask the front desk.

1. **VERIFYING INSURANCE**: **As a courtesy to you.** will verify your insurance for eligibility benefits prior to your new patient appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there are any waiting periods for work to be performed. Any amounts on your treatment plans that are not covered by your insurance, are your financial responsibility.

2. **PAYMENT:** Payment is due **at the time of service.** Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.

3. **INSURANCE INFORMATION**: **New Insurance** as well as **changes in INSURANCE** must be provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being **your** responsibility.

4. **CHANGES IN PERSONAL INFORMATION:** Changes in your address or telephone numbers should be kept current with our office.

5. **REQUESTS FOR ADDITIONAL INFORMATION:** These must be responded to **immediately.** such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being **your** responsibility.

6. **PAYMENT PLANS:** Our office offers Third Party Financing if needed to assist you in paying for any necessary treatment.

7. **BALANCES:** If your account balance exceeds 30 days, you will receive a notice informing you that your account is **overdue**. If you do not pay your balance or arrange a payment plan within 10 days, your account will be turned over to a collection's agency. If this happens, a **collection fee** (currently 39% of the balance) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus.

8. **RETURNED CHECKS:** There will be **$30** fee for all returned checks. The amount of the check plus the fee must be paid within10 days of notification by money order, cash or credit card. Once a check has been returned, this office will no longer accept personal checks for payment.

9. **CANCELLATIONS / FAILED APPOINTMENTS:** We request 24-hours notice if you are cancelling an appointment. There will be a **$50** fee for cancellations made without 24 hours notice and for failed appointments ("no shows"). The $50 will be posted to your account, and you will not be allowed to make any other appointments for yourself or your family members until it is **paid in full.**

*** Thank you for reading this information in full***

*** Please sign below to acknowledge your understanding of the OFFICE POLICIES ***

Patient or Guardian Signature: ______________________________Date: ________________

Patient Name (Please Print): ____________________________________