Brazos Family Dentistry

Confidential Patient Information IF PATIENT IS AN ADULT

Please Print Date______________

Adult Patient's Name

(Last)______________________________(First)_________________________(MI)_________

By what name do you prefer to be called? ___________________

Age__________ Date of Birth___________________ Sex_____Marital Status________________

Home phone ____________________________ Cell Phone_______________________________

Address________________________________ City, State___________________Zip___________

Employer_________________________ Occupation_____________Business Phone____________

Employer Address___________________________ City, State_______________Zip_____________

SS#_______________________________ Driver's License#________________________________

Spouse's Name___________________________________ Date of Birth_________________

Employer________________________ Occupation________________Business Phone___________

Employer Address_________________________ City, State __________________ Zip____________

SS#________________________________ Cell Phone_________________________________

INSURANCE INFORMATION

Insured Name____________________________________Date of Birth of Insured_______________

Insurance Company Name___________________________Group Number______________________

Insurance Company Phone Number____________________ Policy ID Number__________________

We will gladly process your forms if you provide us with the insurance information. This allows you to pay your estimated portion when services are rendered, rather than paying us in full. Necessary forms should be completed and signed by patient and/or insured to expedite insurance carrier payments. If payments are mailed to the patient, payment is requested in full at the time services are rendered unless arrangements have been made.

ACKNOWLEDGEMENT & AUTHORITY

All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services as they are rendered. Fees change without notice. Pre-estimated fees are good for up to six months if treatment does not change. There will be a $25.00 charge for all returned checks. Should this account become delinquent, I understand that I am responsible for all legal fees, court costs, and collection charges involved as a result of any collection activity.

____ ___________________

Signature of Patient Date

Patient Health History

Physician's Name______________________________Office #__________________ Fax#____________________
Pharmacy #___________________________

Please indicate any illnesses or medications you have with a YES or NO.
Detailed information regarding your health is important for your dental team to be aware of. Thank you.

Cancer	_____	Chemotherapy	_____
Rheumatic Fever	_____	Fainting Tendency	_____
Heart Trouble	_____	Anticoagulants/Blood Thinners/daily Aspirin	_____
Abnormal Blood Pressure	_____	Tranquilizers or Sedatives	_____
Chest Pain	_____	Cortisone Drugs (Anti-Inflammatory)	_____
Shortness of Breath	_____	Epilepsy	_____
Asthma or Hay Fever (circle above)	_____	HIV Positive (Human Immunodeficiency Virus)	_____
Sinus Trouble	_____	Tuberculosis	_____
Kidney or Bladder Trouble (circle above)	_____	Diabetes	_____
		Any undesirable effects from any anesthetics	_____
Hepatitis or Jaundice (circle above)	_____	Any difficulties in the past associated with dental treatment?	
Prolonged Bleeding	_____	____	
Severe Headaches	_____		
Do you smoke or use smokeless tobacco? (circle above)	_____	Last Dental Visit	____________________
		For Women Only:	
		Are you taking Birth Control Pills?	________
		Are you pregnant?	________

Females only: Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control for one complete cycle besides just birth control pills after a course of antibiotics is completed.

Have you had any operations? ____
Are you or have you taken Bisphosphonates like Fosamax or Boniva for osteoporosis?__________________
Are you taking any medications, either by prescription or over-the-counter?____________________________
If yes, indicate what kind.____
____
Are you allergic to penicillin?______ What kind of reaction?____
Are you sensitive or allergic to any other medicines?____

EMERGENCY NOTIFICATION

Name of person you would like notified in case of emergency.____
Cell Phone #______________________ Work Phone#______________________
Who may we thank for referring you to our office?___________________________________
Do you have any children?____ What are their names/ages?____

____ ____________________________
Signature of Patient or Parent/Guardian (if patient is a minor) Monique Vu, D.D.S.

Brazos Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement. However, this will render the filing of your insurance claims your responsibility as well as prevent our office from calling any prescriptions that you may need into your pharmacy.

I, ____________________________________, have received a copy of this office's Notice of Privacy Practices or have seen it visibly posted in the office reception area. This release of information is valid while the person above is a patient in this office.

____
Please Print Name

____
Signature

____
Date

____
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 acknowledgement

____ Other (Please Specify)

____

____

Brazos Family Dentistry

Financial Policy

Thank you for choosing Brazos Family Dentistry to provide your dental care. We are committed to providing you the best possible dental care. In order to prevent any misunderstandings, and to serve you better, we ask that all patients/guarantors read and understand our financial policy. We will gladly answer any questions you may have about services provided, fees, financial policy, or any other aspect of your care.

1. **Payment is due at the time services are rendered**

   -Forms of payment: cash, most credit cards, and checks with a valid Tx Driver's License.
   -Inability to make payment at that time may require your appointment to be rescheduled.
   -Deductibles, co-insurance, and non-covered services must be paid at the time of service.

2. **Insurance acceptance and filing**

   -As a courtesy, we will file insurance for you.
   -Changes in insurance should be provided prior to your visit. Present your new insurance card so we can verify your coverage.
   -If you do not inform us of an insurance change, and we have not been able to collect from your previous insurance, you will be responsible for any unpaid balances.
   -Any amount due after insurance pays is your responsibility and due upon notification regardless of any clauses or waiting periods that you may have.

3. **Returned checks**

   -Returned checks will incur a $25.00 fee. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card to prevent further action.
   -Once there is a returned check, we will no longer accept personal checks.

4. **Accounts turned over to a collection agency**

   -Accounts with unpaid balances with no payment activity for 90 days may be turned over to a collection agency.
   -If this happens, a collection fee of 40% of the balance will be added to your account balance.
   -We understand that temporary financial problems may affect timely payment, so we encourage communication of such problems to us at 281-342-0163 so that your account can be properly managed.

5. **Changes in Personal Information**

   -Changes in address or telephone numbers should be kept current with our office. If we are unable to contact you regarding an overdue balance, your account will be turned over to a collection agency.

6. **Missed appointments**

   -Please let us know 24 hours in advance if you cannot keep your appointment.

We are happy to help you maximize the allowable benefits with your dental insurance plan. It is, however, your responsibility to know and understand your own insurance benefits, coverage, pre-existing condition clauses and waiting periods. We will assist you in any way we can with this. We look forward to helping you achieve a healthy and beautiful smile.

I have read and understand the above financial policy.

____________________ ____________________ __________

Printed Name Signature Date

Brazos Family Dentistry

Dear Patient:

I authorize Dr. Monique Vu to keep my signature on file and to charge my Mastercard, Visa, or Discover account as indicated below:

Check one: [ ] Mastercard [ ] Visa [ ] Discover

Balances on my account not paid by insurance within 90 days will be charged to my credit card.

I assign my insurance benefits to the provider listed above. I understand that this form is valid unless I cancel this authorization through notice to the healthcare provider.

- If patient receives dental payment from the insurance company, it is the patient's responsibility to either forward the check to the dental office or write a personal check for the amount of the insurance payment. Failure to do so may result in legal fees, court costs, and collection charges involved as a result of collection activity.

____
Patient Name

____
Cardholder Name

____
Cardholder Billing Address

____
City State Zip

____
Account Number

Exp: Month__________ Year___________

____________________________________ ______________
Cardholder Signature Date