

# Brazos Family Dentistry

## Confidential Patient Information IF PATIENT IS A MINOR

Please Print \_\_\_\_\_ Date \_\_\_\_\_

Child 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 \_\_\_\_\_

### IF THE PATIENT IS A MINOR

Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer \_\_\_\_\_ SS# \_\_\_\_\_

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer \_\_\_\_\_ SS# \_\_\_\_\_

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 Parent/Guardian (if patient is a minor)

\_\_\_\_\_  
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 _____	HIV Positive (Human Immunodeficiency Virus) _____
(circle above)	
Sinus Trouble _____	Tuberculosis _____
Kidney or Bladder Trouble _____	Diabetes _____
(circle above)	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

## **Brazos Family Dentistry**

Monique Vu, D.D.S.  
7615 Town Center Blvd.  
Rosenberg, TX 77471  
281-342-0163  
BrazosDental.com

To provide the best possible care for our patients, we respectfully request the following.

If the patient is under the age of 18, please list the names of the people with whom we may discuss finances, treatment, etc. regarding the patient.

Name:	Relationship to Patient:	Contact Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____