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WELCOME TO OUR OFFICE!

Confidential Information – Please complete and return prior to your appointment

Patient Information

Name _____ **Date** _____/_____/_____

First Name Middle Name/Initial Last Name

What would you like us to call you (preferred name)? _____

Address _____ **City**_____ **State** _____ **Zip** _____

Home Phone _____ **Cell** _____ **Work** _____

Date of Birth ___/___/____ **Social Security #** _____-_____-_____ **Drivers Lic. #** _____

Employer _____ **Occupation** _____

E-mail address _____

In case of Emergency, who should be notified?

Name _____ **Relationship** _____ **Phone** _____

Name _____ **Relationship** _____ **Phone** _____

Who should we thank for referring you? _____

Tell Us About Yourself

The better we understand you, the better we can serve you. We do not like to make assumptions or guess about your needs and wants. Please place an **"X"** along each line indicating your opinion or preference.

I like to be presented with fewer options	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	I like to be presented with more options
I tend to look at the details	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	I tend to look at the big picture
I prefer long-lasting solutions that may cost more	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	I prefer more temporary solutions at lower cost
Insurance largely determines the extent of my care	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	I largely determine the extent of my care

Responsible Party for Payment Information/Primary Dental Insurance

We are committed to making your dental care affordable by offering a variety of payment options as well as making the most of your dental insurance benefits. Our practice is not an insurance driven practice. As a courtesy to you, we file and process all your insurance claims, receive payment and post the credit from your insurance coverage to your account. All policies have limitations and do not cover 100% of the fees charged. Ultimately, it is your responsibility for the total cost of treatment regardless what insurance reimburses.

Person Responsible for Payment: Self _____ Other? _____

If other: Name _____

First Name Middle Name/Initial Last Name

Responsible Party Information (If different from Patient Information)

Address _____ **City**_____ **State** _____ **Zip** _____

Home Phone _____ **Cell** _____ **Work** _____

Date of Birth ___/___/____ **Social Security #** _____-_____-_____ **Drivers Lic. #**_____

E-mail address _____

Employer _____ **Occupation** _____

Insurance/Payment Information

Insurance Company _____ **Phone** _____

Subscriber Name (if different) _____ **Subscriber birthday** _____/_____/_____

Subscriber Social Security # _____-_____-_____

Group Number _____ **Subscriber ID#** _____

Have you used your insurance this year? Yes _____ **No** _____

I prefer to take care of my financial obligations for dental services with…

☐ **Cash** ☐ **Check** ☐ **MasterCard** ☐ **Visa** ☐ **Discover** ☐ **American Express**

☐ **I would like to discuss available financial alternatives**
(I understand if I request alternative financial arrangements, my credit report may be required)

Authorization

I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary. I authorize use of this signature for all submissions.
I understand I am responsible for all charges whether or not they are covered by my insurance, as well as any additional costs. I have reviewed the information on this form and it is accurate to the best of my knowledge.

Signature _____ **Date** _____/_____/_____
Patient or Responsible Party

Acknowledgement of Receipt
Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. **By signing below I consent for the use of my personal health information for treatment, payment, operations and other uses as described in the privacy notice.** I also understand that I have the right not to sign this agreement.

Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____/_____/_____

If we are unable to get your acknowledgement then our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgement was not obtained: _____

_____

_____

_____

Staff Name: _____

Signature: _____

Date: _____/_____/_____

Notice of Privacy
Scott A. Logan, DDS, FAGD

As a provider of medical services we are required, under the Health Insurance Portability and Accountability Act, to inform you of your rights to protect your personal health information. As a covered entity, we must inform all patients of their rights regardless of insurance coverage.

Our Duty To You

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies, but you will be informed of any changes in advance. We will only release information about you and your treatment under specific circumstances. These include, but are not limited to the following:

Treatment: We may use your information during the course of treatment. This includes releasing information to other dentists, physicians, other health care providers and our staff. Our staff includes full and part-time employees as well as temporary personnel.

Payment: We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes insurance carriers, claims clearinghouses, collection agencies and third party administrators such as employee medical reimbursement accounts.

Operations: We may use your information in the course of operations of our office. This may include quality assurance/quality improvement reviews, credentialing, training and certification and accreditation activities.

Miscellaneous Uses: At certain times we may be required to use your information for purposes other than described above. Examples of these uses include: appointment reminders (cards, voice messages and letters), abuse/neglect, national security, family and friends (only to the extent for use in healthcare operations and payment), coroner, workers compensation claims and in some cases to law enforcement and court ordered releases.

Your Rights

Restrictions: You have the right to request restrictions or disclosure usage. We are not required to accept these restrictions but will make a note of the request and honor that request if applicable.

Access: You have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule an appointment to view your information. You may also request a copy of your personal health information. We have the right to charge a fee for the copies as set by the Texas State Board of Dental Examiners.

Amendment: You have the right to request that we amend your personal health information. Your request must be in writing and explain what should be amended and the rationale for such request. We have the right to deny this request if we feel it would render your information inaccurate. We will inform you of the decision to amend your information.

Disclosures: You have the right to request a list of the times and entities to whom we have disclosed your personal health information. These disclosures are only for instances other that treatment, payment or operations. This disclosure will be provided free on an annual basis if requested.

Complaints: Please contact our privacy officer for any questions or complaints. If you feel we have violated your privacy you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address upon request.

Dental History

What is the reason for your visit today? _____

Do you have any immediate concerns? If so, what? _____

Date of your last dental visit _____/_____/_____ Previous Dentist's name _____

What was done at your last dental visit? _____

Why did you leave your last dentist? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING

Personal History

How would you rate the health and condition of your mouth: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Are you having any discomfort at this time? [ ] Yes [ ] No

Have you ever had any unpleasant experiences associated with previous dentistry? [ ] Yes [ ] No

If yes, please describe _____

Are you nervous about dental treatment? *If yes, rate on a scale of 1-10 (ten being terrified)* _____ [ ] Yes [ ] No

If yes, what is your biggest concern? _____

Have you ever had trouble getting numb or had a reaction to local anesthetics? [ ] Yes [ ] No

Have you ever had braces, orthodontic treatment or had your bite adjusted? [ ] Yes [ ] No

Have you had any teeth removed? [ ] Yes [ ] No

Do you wear partial or full dentures? [ ] Yes [ ] No

If yes, are you pleased with the Fit? Function? Appearance? [ ] Yes [ ] No

Smile Characteristics

On a scale of 1-10 (ten being wonderful!), how would you rank the beauty of your smile? _____

Have you ever whitened (bleached) your teeth? [ ] Yes [ ] No

Have you felt uncomfortable or self-conscious about the appearance of your smile? [ ] Yes [ ] No

Have you been disappointed with the appearance of previous dental work? [ ] Yes [ ] No

Is there anything you would like to change about your smile? [ ] Yes [ ] No

Bite and Jaw Joints

Do you have concerns with your jaw joints? (pain, limited opening, locking, popping) [ ] Yes [ ] No

Have your teeth changed in the last 5 years – become shorter, thinner or worn? [ ] Yes [ ] No

Are your teeth shifting, crowding or developing spaces? [ ] Yes [ ] No

Do you have more than one bite, or do you clench to make your teeth fit together? [ ] Yes [ ] No

Do you clench or grind your teeth during the day? [ ] Yes [ ] No

Do you have tension headaches or sore teeth? [ ] Yes [ ] No

Do you ever wake up with headaches? [ ] Yes [ ] No

Do you have problems sleeping or wake up with an awareness of your teeth? [ ] Yes [ ] No

Do you wear, or have you ever worn a bite splint, bite appliance or night guard? [ ] Yes [ ] No

Have you ever had your bite adjusted? [ ] Yes [ ] No

Tooth Structure

Do you consider yourself to be cavity prone? [ ] Yes [ ] No

Do you have sugar habits such as soft drinks, juice, sports/energy drinks, candy, gum? [ ] Yes [ ] No

Do you have a dry mouth? [ ] Yes [ ] No

Are any teeth sensitive to hot, cold, biting or sweets? [ ] Yes [ ] No

Do you avoid brushing any part of your mouth? [ ] Yes [ ] No

Have you ever had a toothache, cracked filling, or broken, chipped or cracked tooth? [ ] Yes [ ] No

Do you have grooves or notches on your teeth near the gum line? [ ] Yes [ ] No

Gum and Bone

Have you ever been diagnosed or treated for periodontal (gum) disease? [ ] Yes [ ] No

Do your gums bleed when brushing, flossing or eating? [ ] Yes [ ] No

Have you noticed an unpleasant taste or odor in your mouth? [ ] Yes [ ] No

Do you have recession of your gums? [ ] Yes [ ] No

Do you have any teeth that have mobility or are loose? [ ] Yes [ ] No

Is there anyone in your family with a history of periodontal (gum) disease? [ ] Yes [ ] No

On a scale of 1-10 (ten being extremely), how important is it for you to keep your teeth? _____

Please share with us any needs, goals, ideas or other information you may have about your general health, oral health or appearance of your smile that would assist us in caring for you ?

_____

_____

_____

_____

Medical History

Name _____ Date of Birth _____/_____/_____

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Physicians Name _____ Date of last physical _____/_____/_____

Are you under the care of a physician at this time? [ ] Yes [ ] No

If yes, please explain _____

_____

Are you currently taking medications, drugs, vitamins or herbal supplements? [ ] Yes [ ] No

Medication/Supplements	Reason	Dosage	Medication/Supplements	Reason	Dosage

Do you have any allergies or adverse reactions to medications or substances? [ ] Yes [ ] No

If yes, please list _____

Do you use any form of tobacco? [ ] Yes [ ] No

If yes, how much? Smoke _____ packs per day Chew/dip _____ cans/packs per day

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

	YES	NO		YES	NO
Acid Reflux/Heart burn/GERD			High Blood Pressure		
Alzheimer's or Dementia			High Cholesterol		
Abnormal Heart Condition			HIV or AIDS		
Artificial heart valve			Intestinal Disease/Disorder		
Arthritis/Rheumatism			Kidney disease		
Artificial Joints/Pins/Screws etc…			Latex Sensitivity		
Abnormal Bleeding after a cut			Migraines		
Bacterial Endocarditis			Neurologic disorders		
Blood Disorder/Anemia			Nighttime Snoring		
Cancer/Cancer Treatment			Osteoporosis/Osteopenia		
Daytime Sleepiness			Pacemaker		
Diabetes			Respiratory disease/problems		
Epilepsy/Convulsions/Seizures			Sinus Problems		
Glaucoma			Sleep Apnea		
Head or Neck Injuries			Stroke		
Hepatitis or Liver Disease			Thyroid disease/problems		

Do you have any other disease, condition or problem not listed? If yes, please list

_____

_____

Women: Are you... **Pregnant** [ ] Yes [ ] No **Nursing?** [ ] Yes [ ] No

Using birth control medication? [ ] Yes [ ] No

I have reviewed the information on this form and it is accurate to the best of my knowledge.

PATIENT SIGNATURE _____ **DATE** _____/_____/_____