
Red Bird family dental

8300 Homestead Rd. Ste 3
Houston, TX 77028
TEL: 713-631-3700
FAX: 866-541-5149

WWW.RBFDENTAL.COM

## Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred)

Gender: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married

Date of Birth: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (EXT) _____ (Mobile)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

## Policy Holder/Responsible Party Information

**Please circle one:** Spouse – Parent – Guardian – Self

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred)

Gender: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married

Date of Birth: _____ Email Address: _____

(If different from patient)

Phone: _____ (Home) _____ (Work) _____ (EXT) _____ (Mobile)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

**Who may we thank for referring you?** _____

Red Bird Dental Group
Red Bird family dental

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# Consent for Dental Services

I. I agree to be responsible for payments of all services rendered on behalf of myself and/or my dependants. I understand that payment is due at the time of service and in-office financing is available upon request.

II. I understand that any out-of-pocket fee quoted at the time of service is an estmiate; I am responsible for any difference pursuant to my insurance carrier's contracted rates, as detailed on my Explanation of Benefits.

III. I am aware that as a courtesy Red Bird Dental's staff will bill my dental insurance. If a dental pre-authorization has not been submitted, the quoted out of pocket expense will be based on the majority of dental plans. It is not uncommon for insurance companies to have waiting periods for certain procedures. It is my responsibility to review my plan booklet or check with my insurance company to be sure that my scheduled care falls within their guidelines.

IV. I hereby authorize doctor (or designated staff) to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of dental needs.

V. I understand that the use of anesthetics and sedatives may be necessary and with their use embodies certain risks. I am aware that by my request, I am entitled to a complete recital of potential complications.

VI. I agree to notify the office as soon as possible if something arises and I need to reschedule an appointment. I am aware that if I miss three appointments without informing the office prior, I may be dismissed from the practice.

VII. If required, I authorize Red Bird Dental to check my credit.

**Signature**_____ **Date**_____

# Patient Health History

## Medical History

Are you currently under a physicians care? Y N
Physicians Name_____
Phone #:_____

**Are you taking any medications?** Y N
Please list medications and why:
(Example=Lisinopril-High Blood Pressure)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**For Women Only:**
Are you taking birth control pills? Y N
Are you pregnant or trying? Y N
Due Date_____ Are you nursing? Y N

**Are you allergic to any of the following?:**
(Please Circle all that apply)
Aspirin
Erythromycin
Codeine
Penicillin
Tetracycline
Anesthetics

Please list any other drugs/medications you are allergic to:_____

_____
_____
_____
_____
_____
_____
_____
_____
_____

**Have you ever had any of the following diseases or medical problems?**

Y N High Blood Pressure
Y N HIV+/ARC/AIDS
Y N Kidney Problems
Y N Liver Problems
Y N Pacemaker
Y N Psychiatric Therapy
Y N Seizures
Y N Sickle Cell Trait/ Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Disease
Y N Ulcers
Y N Anemia
Y N Arthritis
Y N Artificial Joints
Y N Heart Valves or Replacements
Y N Asthma
Y N Bleeding Problems
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema

Please list any other medical conditions that you want the doctor to know about:

_____
_____
_____
_____
_____
_____
_____

EMERGENCY CONTACT NAME AND PHONE NUMBER:

_____
_____
_____
_____

## Informed Consent For Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. My signature will also serve as a release should I request treatment or radiographs be sent to other attending Doctors in the future.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize Red Bird Dental, all associated subsidiaries and its employees to contact me with information regarding my dental appointments, treatment, billing, health, and services. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. Please list any other parties who can have access to your dental information.

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I have been informed and consent to these notices and release information to the above person(s)

Patient Full Name_____ Parent/Guardian Name _____

Relationship to Patient _____

Patient/Parent/Guardian Signature _____

Date _____

# Dental History

Are you currently in pain? Y N

Do you require antibiotics before dental treatment? Y N

Have you ever been hospitalized or had a major operation? Y N

Do you smoke, chew, or use E-cigarettes? Y N

**Have you ever been informed or treated for the following dental conditions:**

Y N Bleeding Gums
Y N Bad Taste/Odor
Y N Cold Sores/Ulcers
Y N Hot/Cold Sensitivity
Y N Deep Cleanings/Scalings
Y N Loose Teeth
Y N Oral Cancer/Biopsy
Y N Wisdom Teeth Extraction

## Dental Insurance Info

Name of Subscriber: _____ _____ _____
Last First MI

Date Of Birth: _____

SS/ID #: _____

Insurance Company Name: _____

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# VIDEO SURVEILLANCE CONSENT FORM

**Red Bird Dental authorizes the use of video surveillance equipment on this property to enhance the safety of the staff and patients as well as others on these premises and to deter inappropriate behavior.**

**Video monitors used to view recordings are not located in a position that enables public viewing.**

**Red Bird Dental is responsible for the proper implementation and control of the video surveillance system.**

_____ _____

**Signature** **Date**