NORTH TEXAS
DENTAL SURGERY

PATIENT INFORMATION

Patient's Legal Name _____ Preferred Name _____

Birthdate _____ SS#_____ Sex _____ Height _____ Weight (lbs.) _____

Cell Phone_____ Home Phone _____

Home Address _____ City _____ State _____ Zip _____

Email _____

Employer _____ Occupation _____

Who may we thank for referring you to our office? _____

Are you currently under the care of a dental provider (i.e. general dentist, orthodontist, etc.)? ❑ no ❑ yes

If yes, please indicate provider name: _____

Is an immediate family member a patient here? ❑ no ❑ yes Name: _____

INSURANCE INFORMATION: ❑ Not covered by dental insurance.

Policy Holder Name_____ Policy Holder Date of Birth _____

Policy Holder Employer _____

Policy Holder ID or Social Security # _____ Dental Insurance Name_____

Group Number _____ Phone Number _____

PHARMACY INFORMATION (IF WE DON'T RECEIVE THIS INFORMATION, NO PRESCRIPTIONS WILL BE SENT):

Name _____ Phone Number_____

Address _____

City _____ Zip _____ State _____

EMERGENCY CONTACT INFORMATION:

Name of nearest relative _____

Relationship to patient _____

Contact Number _____

Patient's Signature: _____ Date: _____

Parent/Guardian *(if patient is a minor):* _____

HEALTH HISTORY FORM

Patient's Name _____ **Date of Birth** ____/____/____

Gender _____ **Height** _____ **Weight** _____ **Today's Date** _____

An accurate and complete health history will assist in coordinating your dental care.
Please speak with the doctor or staff if there are any questions about this form.

DENTAL HISTORY

Please describe your current dental health: Excellent Good Fair Poor

Please describe why you are in the office today_____

Have there been any changes in your dental health in the past year? Yes / No

If yes, please describe_____

Are you having any dental discomfort at this time? Yes / No

If yes, please describe_____

Have you had any adverse effects from dental treatment? Yes / No

If yes, please describe_____

Date of last dental visit?_____

DENTAL HISTORY - Do you have or have you ever had any of the following:

Bleeding, sore gums?	Yes / No	Shifting in bite?	Yes / No
Unpleasant taste/bad breath?	Yes / No	Change in bite?	Yes / No
Swelling/lumps in mouth?	Yes / No	Burning tongue/lips?	Yes / No
Orthodontic treatment (braces?)	Yes / No	Frequent blister, lips/mouth?	Yes / No
Clenching/grinding?	Yes / No	Sensitive teeth (hot or cold?)	Yes / No
Sensitive to sweets?	Yes / No	Clicking/popping jaw?	Yes / No
Sensitive to biting?	Yes / No	Difficulty opening or closing jaw?	Yes / No
Food Impaction?	Yes / No	Loose teeth?	Yes / No
Biting cheeks/lips?	Yes / No		

MEDICAL HISTORY

Please describe your current overall health: Excellent Good Fair Poor

Have there been any changes in your general health in the past year? Yes / No

If yes, please describe:

_____

Are you now under a doctor's care for a medical condition? Yes / No Date of last physical exam?_____

If yes, please describe_____

MANTRA ORAL SURGERY

HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

Name of physician_____ Physician phone number_____

Have you ever been hospitalized or had a serious illness? Yes / No
If yes, please describe_____

Have you ever had surgery? Yes / No
If yes, please describe_____

_____

_____

_____

MEDICAL HISTORY (continued) - Do you have, or have you ever had, any of the following conditions:

Congenital heart disease, cardiovascular disease – like heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker?	Yes / No	Lung disease – like asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?	Yes / No
Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee?	Yes / No	Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily?	Yes / No
Kidney disease or kidney failure, requiring dialysis?	Yes / No	Liver disease – like jaundice, hepatitis A, B, or C?	Yes / No
Thyroid disease?	Yes / No	Arthritis?	Yes / No
Stomach ulcers or colitis?	Yes / No	Significant weight loss or gain?	Yes / No
Diabetes?	Yes / No	Sinus or nasal problems?	Yes / No
Glaucoma?	Yes / No	Sleep apnea?	Yes / No
Cancer?	Yes / No	Osteoporosis or osteopenia?	Yes / No

If yes, type_____. .

Diagnosis date_____

Treatments_____

Do you have any other medical conditions that are important for your doctor to know about? Yes / No
If yes, please describe_____

_____

FAMILY MEDICAL HISTORY - Do you have a family history of any of the following conditions?

Diabetes?	Yes / No	Relationship_____	Heart disease?	Yes / No	Relationship_____
Lung disease?	Yes / No	Relationship_____	Bleeding problems?	Yes / No	Relationship_____
Cancer?	Yes / No	Relationship_____			

Has an immediate family member had any problems with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No
If yes, please describe_____

HEALTH HISTORY FORM

Patient's Name _____ Today's Date

MEDICATIONS (continued): Please list the specific medications indicated above and/or any other medications not listed above that you are currently taking. Please including all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

Medication and dose	Medication and dose

MEDICATIONS – Are you currently prescribed or taking any of the following:

Antibiotics?	Yes / No	Prescription pain medication?	Yes / No
Anticoagulants or blood thinners?	Yes / No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes / No
Heart medications?	Yes / No	Insulin or oral anti-diabetic drugs?	Yes / No
Steroids – like cortisone or prednisone?	Yes / No	Blood pressure medications?	Yes / No
Antianxiety agents, antidepressants, or other psychiatric medications?	Yes / No	Bisphosphonates or other medications to strengthen your bones?	Yes / No
Cancer or chemotherapy drugs?	Yes / No	Any other medications or supplements?	Yes / No

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

Latex?	Yes / No	Codeine or other pain control medications?	Yes / No
Food or food products?	Yes / No	Aspirin, ibuprofen (Motrin), or naproxen (Aleve)?	Yes / No
Sedatives or barbiturates?	Yes / No	Penicillin or other antibiotics?	Yes / No
Any other medications?	Yes / No	Any other allergies?	Yes / No

If yes, please describe_____

_____

_____

ANESTHESIA HISTORY

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No

If yes, please describe_____

FEMALE PATIENTS Are you pregnant? Yes / No Is there any chance you might be pregnant? Yes / No

SOCIAL HISTORY

HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

Have you ever smoked, vaped or chewed tobacco? Yes / No
If yes, for how long?_____

Have you ever sought professional care or been hospitalized for:
Substance abuse Yes / No
Emotional disorders Yes / No
Alcoholism Yes / No

Do you use:
Alcohol? Yes / No If yes, how often per week?_____
Marijuana? Yes / No If yes, how often per week?_____
Recreational drugs? Yes / No If yes, how often per week?_____

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? Yes / No

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care.
To the best of my knowledge, the above information is complete and correct.

_____
Signature of patient, parent, guardian Date

_____
Printed name of patient, parent, guardian/Relationship

For office staff use - HEALTH HISTORY REVIEW

Date	Comments	Doctor's Signature
_____	_____	
_____	_____	
_____	_____	
_____	_____	

For office staff use - ADDITIONAL CLINICAL DOCUMENTATION

_____

_____

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MEDICAL HEALTH HISTORY CONT.

If you have marked "No" to any of the following medical conditions on the previous page, you may leave this page blank.

If you have marked "Yes" to any of the following medical conditions on the previous page:

- Stroke
- Radiation Treatment/Chemotherapy
- Any Heart Related issues **(such as Heart Attack/Disease, Heart Failure, Heart Murmur, Heart Surgery, Defibrillator and Pacemaker)**
- Gastric Bypass

Please be as detailed as possible. For example, the date & year, extreme detail about the condition, etc.:

_____

_____

_____

_____

Neurologist information (REQUIRED):

Cardiologist information (REQUIRED):

Oncologist information (REQUIRED):

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, filing insurance, and health care operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice at any time.

North Texas Dental Surgery
ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

Patient's Name: [redacted] Date: [redacted]

Please list person(s) we can release information to on your behalf:

[redacted]

[redacted]
Patient's Signature

[redacted]
Signature of Parent/Guardian responsible for Patient (if under the age of 18)

-OR-

Signature of Personal Representative:

_____

NORTH TEXAS
DENTAL SURGERY

Office Policies

Insurance Policy:

NTDS is in-network with all major PPO insurance companies, **EXCEPT** United Concordia.

Upon verifying your benefits, we will provide an estimate prior to your treatment. Please note, it is not guaranteed that your insurance will cover the treatment as estimated.

In the event you have limited coverage, you will be responsible for any charges and/or fees billed to your insurance company where payment is denied.

Medical Denials:

- Medical insurance will cover some oral surgeries, as some medical conditions may entitle you to dental coverage under your health insurance.
- Some dental insurance policies require that you bill the medical insurance company first, and once that claim is processed you can file a claim toward dental insurance. **This is when a Medical Denial is required.**
- To ensure your treatment can be done in a timely manner, we will collect for any procedure that requires medical denial up front.
- Upon request, we will provide the medical claim form for you to submit to your medical insurance carrier. Once you submit the medical claim form, the explanation of benefits (EOB) will be mailed to you. **Please note that this process could take a few months for completion.** When you have received your EOB, send us a copy, and we will submit it to your dental insurance carrier on your behalf.

- Patient initial: _____

Primary and Secondary Insurance:

- NTDS will verify both primary and secondary insurance.
- Your primary insurance will apply at the time of treatment. We cannot show estimated coverage with your secondary insurance until we bill the primary insurance.
- NTDS will bill your primary insurance for treatment.
- **Once we receive the EOB back from your primary, we will bill your secondary. Secondary insurance requires an EOB from the primary insurance before a claim can be sent.**

- Patient initial: _____

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Predeterminations:

- A predetermination (pre-d) of benefits is a review by your insurer's dental staff, to determine if they agree with your treatment that we have recommended for your dental needs.
- **Predeterminations are done prior to your treatment, to ensure you understand what is covered vs what is not covered by your dental insurance plan.**
- Patient Initial: _____

Payment Policy:

For your convenience, NTDS accepts that following forms of payment:

- Debit cards
- All major credit cards (Visa, Master Card, and American Express)
- Care Credit
- Proceed Finance
- Check
    - **Please note, NTDS must receive all checks AT LEAST 5 business days prior to your surgery. NTDS requires the FULL amount to clear the bank prior to the date of your surgery.**
- Patient Initial: _____

Deposit Policy:

NTDS will collect the following deposits upon scheduling your surgery. Please note, all deposits will go towards your total treatment amount.

- All on 4:
    - Day of initial impressions:
      Total balance is due in full.
- All other surgeries: **Remaining balances for the below surgeries are due in full 7 days before the surgery.**
    - Implants: $200 (deposit)
    - Wisdom teeth: $200(deposit)
    - Frenectomy: $200(deposit)
    - Gingivectomy: $200(deposit)
    - SRP (deep cleaning): $200
    - Expose & Bond: $200(deposit)
    - Incision & Drainage: $200(deposit)
    - Impressions: $200(deposit)
    - Tissue Graft: $300(deposit)
    - Osseous: $300(deposit)
    - LANAP: $300(deposit)
- Friday surgeries will require the balance due in full at the time of scheduling.
- Patient Initial: _____

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Rescheduling Policy:

- All on 4, LANAP and Osseous surgeries:
  - All on 4, LANAP and Osseous surgeries must be rescheduled **AT LEAST 14 calendar days in advance.**
  - Due to scheduling difficulty for our surgeon and prosthodontist, rescheduling an All on 4 surgery less than 7 calendar days in advance, is subject to the following nonrefundable office fees.
    - 7 calendar days or less = $2,500
- All other surgeries:
  - Surgeries scheduled Monday – Thursday must be rescheduled **AT LEAST 5 calendar days in advance.**
- Rescheduling a Monday -Thursday surgery (i.e. wisdom teeth, implants, extractions, etc.) less than 5 calendar days in advance, is subject to the following nonrefundable office fees.
  - Rescheduling one time =$200
  - Rescheduling two times = $400
  - Rescheduling three times = NTDS will no longer accept you as patient
- Surgeries scheduled on Fridays must be rescheduled AT LEAST 7 calendar days in advance.
- Rescheduling a Friday surgery (i.e. wisdom teeth, implants, extractions, etc.) less than 7 calendar days in advance, is subject to the following office fees.
  - 7 calendar days or less = $400 nonrefundable office fee

- Patient Initial: _____

NO SHOW Policy:

- All on 4 surgeries: $7,000 nonrefundable fee
- LANAP and Osseous surgeries: $3,000 nonrefundable fee
- All other surgeries:
  - $500 nonrefundable fee

- Patient Initial: _____

I, _____ have read, understand, and agree to NTDS's Insurance Policy, Payment Policy, Deposit Policy, and Rescheduling Policy. I understand failure to abide by these office policies could result in cancelation of my treatment and procedure.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (minor patients): _____