NORTH TEXAS
DENTAL SURGERY

PATIENT INFORMATION

Patient's Legal Name _____ Preferred Name_____

Birthdate _____ SS#_____ Sex_____

Cell Phone _____ Home Phone _____

Home Address _____ City _____State _____ Zip _____

Email _____

Employer _____ Occupation _____

Whom 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

Polocy Holder Name _____ Policy Holder Date of Birth_____

Policy Holder Employer _____

Policy Holder ID or Social Security # _____ Dental Insurance Name _____

Group Number _____ Phone Number _____

PREFERRED 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):* _____

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MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

✈ no	✈ yes	AIDS/HIV Positive
✈ no	✈ yes	Allergies or Hives
✈ no	✈ yes	Anemia
✈ no	✈ yes	Angina Pectoris
✈ no	✈ yes	Anxiety
✈ no	✈ yes	Arthritis
✈ no	✈ yes	Artificial Joint or Heart Valve
✈ no	✈ yes	Asthma
✈ no	✈ yes	Autoimmune Disorder
✈ no	✈ yes	Blood Transfusion
✈ no	✈ yes	Bruise Easily
✈ no	✈ yes	Chemotherapy
✈ no	✈ yes	Cold Sores/Fever Blisters
✈ no	✈ yes	Congenital Heart Defects/Lesions
✈ no	✈ yes	COPD
✈ no	✈ yes	Cortisone Medicine
✈ no	✈ yes	Cough (persistent)
✈ no	✈ yes	Diabetes: **Type 1/Type 2 A1C**: _____
✈ no	✈ yes	Emphysema
✈ no	✈ yes	Epilepsy/Seizures
✈ no	✈ yes	Fainting/Dizzy Spells
✈ no	✈ yes	Gastric Bypass
✈ no	✈ yes	Glaucoma
✈ no	✈ yes	Heart Attack/Disease
✈ no	✈ yes	Heart Failure
✈ no	✈ yes	Heart Murmur
✈ no	✈ yes	Heart Surgery
✈ no	✈ yes	Hepatitis A or B or C
✈ no	✈ yes	High/Low Blood Pressure
✈ no	✈ yes	Kidney Trouble
✈ no	✈ yes	Liver Disease
✈ no	✈ yes	Mitral Valve Prolapse
✈ no	✈ yes	Osteoporosis
✈ no	✈ yes	Pacemaker/Defibrillator
✈ no	✈ yes	Plastic Surgery
✈ no	✈ yes	Psychiatric Treatment
✈ no	✈ yes	Radiation Treatment
✈ no	✈ yes	Rheumatism
✈ no	✈ yes	Sleep Apnea
✈ no	✈ yes	Sickle Cell Disease/Traits
✈ no	✈ yes	Stroke/TIA
✈ no	✈ yes	STD or VD
✈ no	✈ yes	Thyroid Disease
✈ no	✈ yes	Tuberculosis
✈ no	✈ yes	Ulcers/Colitis

Other: _____

Height: _____ **Weight:** _____

Women:

✈ no ✈ yes May be pregnant
✈ no ✈ yes Taking hormones or contraceptives.

Are you allergic to, or have you reacted adversely to any of the following?

✈ no	✈ yes	**Latex materials**
✈ no	✈ yes	**Penicillin :**
		Circle: Sensitive or Anaphylactic
✈ no	✈ yes	**Other Antibiotics : _____**
✈ no	✈ yes	**Local anesthetics ("Novocain")**
✈ no	✈ yes	**Codeine or other narcotics**
✈ no	✈ yes	**Sulfa drugs**
✈ no	✈ yes	**Aspirin**
✈ no	✈ yes	**Barbiturates, sedatives, or sleeping aides**.

Other: _____

****Do you need to pre-medicate before any procedure due to an artificial joint** (i.e. hip/knee replacement)**?**

✈ no ✈ yes

Are you taking any of the following?

✈ no ✈ yes **Anticoagulants** (i.e Aspirin, Coumadin/Warfarin, Plavix, Xarelto/ Rivaroxaban)

✈ no ✈ yes **Antiresorptive** (i.e Fosamax, Actonel, Zometa, Boniva, Reclast, Aredia, Xgeva)

✈ no ✈ yes **Antibiotics** (i.e Amoxicillin, Augmentin, Clindamycin, Zithromax)

✈ no ✈ yes **High blood pressure medicine** (i.e Amlodipine, Metoprolol, Losartan, Lisinopril)

✈ no ✈ yes **Antidepressants or tranquilizers** (i.e Prozac, Luvox, Celexa, Cipralex)

✈ no ✈ yes **Cancer medications** (i.e Sutent, Nexavar, Avastin, Rapamune, Zolendronate)

✈ no ✈ yes **Diabetic medicine** (i.e Insulin, Metformin, Semaglutide, Ozempic)

✈ no ✈ yes **Nitroglycerin**

✈ no ✈ yes **Corticosteroids** (i.e Prednisone, Dexamethasone, Decadron, Cortisone)

✈ no ✈ yes **Have you ever taken Phen-Fen/Redux?** (for weight loss)

✈ no ✈ yes **Have you ever taken bisphosphonates?** (Fosamax, Actonel)

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If you have marked "No" to any of the following medical conditions above, you may skip this page.

- AUTOIMMUNE DISEASE
- GASTRIC BYPASS
- PREGNANT
- RADIATION TREATMENT/ CHEMOTHERAPY
- STROKE/TIA (AKA MINI STROKE)

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

- ANY HEART RELATED ISSUES (SUCH AS HEART ATTACK/DISEASE, HEART FAILURE, HEART MURMUR, HEART SURGERY, DEFIBRILLATOR, AND PACEMAKER)

PLEASE BE AS DETAILED AS POSSIBLE. FOR EXAMPLE, THE DATE & YEAR, EXTREME DETAIL ABOUT THE CONDITION, ETC.

_____

_____

_____

_____

NEUROLOGIST INFORMATION (REQUIRED):

DOCTOR: _____

PHONE: _____

FAX: _____

DATE OF LAST VISIT: _____

CARDIOLOGIST AND/OR ELECTROPHYSIOLOGIST INFORMATION (REQUIRED):

DOCTOR: _____

PHONE: _____

FAX: _____

DATE OF LAST VISIT: _____

ONCOLOGIST INFORMATION (REQUIRED):

DOCTOR: _____

PHONE: _____

FAX: _____

DATE OF LAST VISIT: _____

OBGYN INFORMATION (REQUIRED)

DOCTOR: _____

PHONE: _____

FAX: _____

DATE OF LAST VISIT: _____

RHEUMATOLOGIST INFORMATION (REQUIRED):

DOCTOR: _____

PHONE: _____

FAX: _____

DATE OF LAST VISIT: _____

PRIMARY CARE PHYSICIAN (REQUIRED):

DOCTOR: _____

PHONE: _____

FAX: _____

DATE OF LAST VISIT: _____

Patient initial: _____

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Please list **ALL** the current medications you are taking to include vitamins and supplements.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

***The following information is important for your safety during treatment**:

Alcohol Usage: ✈ NONE ✈ Quit

How long ago? _____

✈ Daily ✈ Weekly ✈ Socially ✈ Occasionally

Have you or do you currently smoke or vape or use tobacco products?

✈ no ✈ yes ✈ never ✈ Quit

How long ago? _____

✈ Daily ✈ Weekly ✈ Socially ✈ Occasionally

Have you or do you currently use illicit drugs?

✈ no ✈ yes ✈ Quit

How long ago? _____

✈ Daily ✈ Weekly ✈ Socially ✈ Occasionally

If yes, what_____

Do you have a history of drug abuse? ✈ no ✈ yes

☐Alcohol ☐Meth ☐MJ ☐Cocaine ☐Opioids ☐Other

Have you been hospitalized and/or had a serious operation or illness within the last five years? ✈ no ✈ yes
Do you have any disease, conditions, or problems **not** listed above?

_____

CONSENT: *I _____, authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the Patient and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand that the use of anesthetic agents embodies a certain risk.*

Patient's Signature: _____ Date: _____

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

Relationship to Patient: _____

NORTH TEXAS
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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: _____Date: _____

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

_____

_____ _____

Patient's Signature **Signature of Parent/Guardian responsible for Patient (if under the age of 18)**

-OR-

Signature of Personal Representative:

_____

Patient initial: _____

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Informed Consent for Dental Treatment

Purpose:

The purpose of this form is to obtain your consent for dental examination, diagnosis, bone measurements and x-rays. All xrays taken will not look at anything non dental related or extraoral- only for intraoral dental diagnosis purposes only.

Risks and Complications:
I understand that as with any dental procedure, there are possible risks including, but not limited to:
- Sensitivity, pain, or discomfort
- Need for additional treatment or referral

Patient Rights and Responsibilities:
I understand that I have the right to:
- Be informed about the nature and purpose of the proposed treatment to include the cost and insurance coverage
- Ask questions and receive answers to my satisfaction
- Accept or refuse treatment
- Request alternative options, if available

Consent Acknowledgment:
By signing below, I acknowledge:
- I have had the opportunity to ask questions
- I authorize the dentist and team to perform the dental examination, diagnosis, bone measurements and x-rays.
- This consent is valid for ongoing dental care unless revoked in writing.

Patient's Signature: _____ Date: _____

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

Relationship to Patient: _____

Patient initial: _____

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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. When you have received your EOB, send us a copy, and we will submit it to your dental insurance carrier on your behalf.

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.**

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: _____

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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
- Lending Club
- Cherry 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.**

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 "X":

    - Day of initial exam the total payment is due in full.

      ****If the patient is following the out of town timeline, the total payment is due at least 3 weeks prior to surgery.

- **FULL payment is due for ALL other surgeries at the time they are scheduled.**
- Cleanings and new patient exams require a $25 deposit at the time of scheduling

Rescheduling Policy:

- All on X initial exams (impressions) must be rescheduled AT LEAST 7 calendar days in advance.
    - 7 calendar days or less = $100
- Initial exams cancelled more than once will require a $100 deposit to rebook. $100 deposit will go towards your treatment unless you cancel for a third time, $100 deposit is nonrefundable for third cancellation.
- All on X, LANAP and Osseous surgeries:
    - All on X, LANAP, Osseous, Tissue grafts, and Ridge Augmentation(GBR) surgeries must be rescheduled **AT LEAST 7 calendar days in advance.**
    - Due to scheduling difficulty for our surgeon and prosthodontist, rescheduling and All on X surgery less than calendar days in advance, is subject to the following nonrefundable office fees.
        - All on X = $2,500 per arch
        - LANAP,Osseous, Tissue Grafts and Ridge Augmentation (GBR) = 50% of out of pocket cost
        - All on X - 5 month post op **(after one-time courtesy)** = $500
        - All on X - Trial teeth delivery **(after one-time courtesy)** = $250

Patient initial: _____

- All other surgeries:
  - Surgeries scheduled Monday – Friday must be rescheduled **AT LEAST 7 calendar days in advance.**
- Rescheduling a Monday -Friday surgery (i.e. wisdom teeth, single implants, extractions, etc.) less than 7 calendar days in advance, is subject to the following nonrefundable office fees.
  - Rescheduling one time = $400
  - Rescheduling two times = NTDS will no longer accept you as a patient.
- Cleanings and new patient exams must be cancelled at least 7 calendar days in advance otherwise $25 deposit is nonrefundable.

- If at any point in time an individual has a documented injury, medical condition, illness or death of an immediate family member that prevents them from making it to their appointment, NTDS will waive all cancellation fees (if applicable) entirely.

NO SHOW POLICY:

- All on X surgeries: $8,000 nonrefundable fee
- LANAP,Osseous surgeries,Tissue Grafts, and Ridge Augmentation: $3,000 nonrefundable fee
- All other surgeries: $500 nonrefundable fee

I, _____ have read, understand, and agree to NTDS's Insurance Policy, Payment Policy, Deposit Policy, No show Policy and Rescheduling Policy. I understand failure to abide by these office policies could result in cancelation of my treatment and procedure.

I, _____ understand that as an independent organization, North Texas Dental Surgery reserves the right to dismiss me as a patient or refuse services at any point of the treatment. Reasons for dismissal include but are not limited to, patient continuous negligence to protocol, patient disrespect or harm to doctors or staff, etc.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (minor patients): _____

NORTH TEXAS
DENTAL SURGERY

Disclosure of Patient Photographic and/or Video Images

I authorize **North Texas Dental Surgery** to use and disclose my **name, photographic and/or video images, and/or testimonial** for **marketing, educational, and advertising purposes**.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by **HIPAA privacy regulations**.

I understand that I may revoke this authorization at any time; however, such revocation must be **in writing** and **sent to the practice via registered mail**. Revocation will apply only to future uses and disclosures and will not affect any actions already taken in reliance on this authorization.
This authorization will **expire 99 years** from the date of signature.

I understand that **my treatment, payment, or eligibility for benefits will not be conditioned** on whether I sign this authorization.

☐ Yes I Approve : _____ ☐ No I Decline: _____

_____
Patient Name (Print) Date

_____
Signature of Patient Date

If Patient Is a Minor

_____
Patient Name (Print) Date

_____
Signature of Parent/Guardian Date