

WELCOME TO OUR PRACTICE

Please share the following information with us:

Patient's Name: _____ Preferred Name: _____

Spouse's Name: _____

Patient's Address: _____ city/zip _____

Home Phone #: () _____ Work Phone #: () _____

Cell # () _____ Email Address: _____

Date of Birth: _____ Social Security #: _____

Driver's License #: _____ State of License: _____

Employer: _____ Present Position: _____

Business Address: _____

Whom may we thank for referring you: _____

FAMILY ACCOUNT INFORMATION

Person Responsible for Account: _____

Current Address: _____ Employed By: _____

Business Address: _____ Business Phone #: _____

Date of Birth: _____ Social Security Number: _____

Insurance Co. Name: _____ Phone Number: _____

Company Providing Insurance: _____

Name of other Family Members:

I UNDERSTAND THAT A FINANCE CHARGE WILL BE ACRUED ON ACCOUNTS OUTSTANDING OVER 60 DAYS. OUR OFFICE MAY OBTAIN A CREDIT REPORT TO FACILITATE MAKING FINANCIAL ARRANGEMENTS.

Signature of person responsible for account: _____ Date: _____

PATIENT MEDICAL AND DENTAL HISTORY

Patient's Name: _____

What is your present problem? _____

Who was your previous dentist? _____ Where is he/she located? _____

When was your last dental exam? _____

Have you had major treatment? Please List: _____

Is there a history of periodontal disease in your family? _____

What do you like MOST about your smile, teeth? _____

What do you like LEAST about your smile, teeth? _____

Do you give us permission to take photographs of your teeth and smile? _____

DO YOU HAVE OR USE ANY OF THE FOLLOWING? IF YES, PLEASE EXPLAIN.

Sensitivity to hot, cold, sweets, or pressure: _____

Bleeding gums/receding gums: Yes ___ No ___

Food impaction between your teeth: Yes ___ No ___ Swelling or lumps in your mouth: Yes ___ No ___

Has anyone (family, friend, etc) ever suggested that you should have something done with your teeth? Yes ___ No ___

Do you avoid smiling when you have your picture taken? Yes ___ No ___

Clenching or grinding of your teeth? Yes ___ No ___ Do you hear popping noises while eating? Yes ___ No ___

Do you wear a night guards or orthotic? Yes ___ No ___

Pain or ringing in your ears? Yes ___ No ___ Do you have frequent headaches? Yes ___ No ___

Do you favor one side when you chew? Yes ___ NO ___

Any bad breath or unpleasant taste? Yes ___ No ___ Do you wear a sleep apnea appliance? Yes ___ No ___

Have you had any gum treatments by specialists? Yes ___ No ___ Have you worn braces or retainers? Yes ___ No ___

How often do you brush your teeth? _____ How often do you floss? _____

Physician's Name: _____ Date of last physical: _____

Location: _____

Who do we notify in case of emergency? _____ Phone number: _____

Do you smoke? _____ Dip? _____

Do you drink alcoholic beverages? _____ More than one a day? _____

Is there any medical reasons why we cannot take radiographs? _____

Please list all medications (include over the counter medications and Vitamins) that you are currently taking:

Please place a check mark next to ALL of the following concerns you have had in the past regarding dental treatment to improve your smile:

Fear of Treatment ___ Time of treatment ___ Financial Concerns ___ Not Understanding Treatment ___

Embarrassment over amount of treatment needed ___ Other _____

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

- | | |
|--|---|
| 1. <input type="checkbox"/> Yes <input type="checkbox"/> No: High blood pressure | 25. <input type="checkbox"/> Yes <input type="checkbox"/> No: HIV infection |
| 2. <input type="checkbox"/> Yes <input type="checkbox"/> No: Rheumatic Fever/Heart Murmur | 26. <input type="checkbox"/> Yes <input type="checkbox"/> No: Thyroid Disease |
| 3. <input type="checkbox"/> Yes <input type="checkbox"/> No: Mitral Valve Prolapse/Regurgitation | 27. <input type="checkbox"/> Yes <input type="checkbox"/> No: Systemic Lupus/Auto-immune disease |
| 4. <input type="checkbox"/> Yes <input type="checkbox"/> No: Irregular or Rapid heart beats/Arrhythmia | 28. <input type="checkbox"/> Yes <input type="checkbox"/> No: Immunosuppressive disorder |
| 5. <input type="checkbox"/> Yes <input type="checkbox"/> No: Congestive Heart Failure | 29. <input type="checkbox"/> Yes <input type="checkbox"/> No: Organ Transplant/Implant |
| 6. <input type="checkbox"/> Yes <input type="checkbox"/> No: Heart Problems or attack/Chest pain/Angina | 30. <input type="checkbox"/> Yes <input type="checkbox"/> No: Allergy to Penicillin/Sulfa Drugs |
| 7. <input type="checkbox"/> Yes <input type="checkbox"/> No: Bypass surgery/Angioplasty | 31. <input type="checkbox"/> Yes <input type="checkbox"/> No: Allergy to aspirin/codeine |
| 8. <input type="checkbox"/> Yes <input type="checkbox"/> No: Artificial Heart Valve | 32. <input type="checkbox"/> Yes <input type="checkbox"/> No: Allergy to Dental anesthetics |
| 9. <input type="checkbox"/> Yes <input type="checkbox"/> No: Pacemaker | 33. <input type="checkbox"/> Yes <input type="checkbox"/> No: Allergy to Latex products |
| 10. <input type="checkbox"/> Yes <input type="checkbox"/> No: Stroke/Dizzy spells/Headaches | 34. <input type="checkbox"/> Yes <input type="checkbox"/> No: Allergy related skin disorders |
| 11. <input type="checkbox"/> Yes <input type="checkbox"/> No: Breathing Problems/Pneumonia | 35. <input type="checkbox"/> Yes <input type="checkbox"/> No: Allergy related nose/sinus problem |
| 12. <input type="checkbox"/> Yes <input type="checkbox"/> No: Hepatitis/Jaundice/Liver Disease | 36. <input type="checkbox"/> Yes <input type="checkbox"/> No: Food or other allergy |
| 13. <input type="checkbox"/> Yes <input type="checkbox"/> No: Emphysema/Asthma/Hay Fever | 37. <input type="checkbox"/> Yes <input type="checkbox"/> No: Behavioral/Psychiatric Disorders |
| 14. <input type="checkbox"/> Yes <input type="checkbox"/> No: Ulcers/Colitis | 38. <input type="checkbox"/> Yes <input type="checkbox"/> No: Anxiety/Depression/Nervous Disorders |
| 15. <input type="checkbox"/> Yes <input type="checkbox"/> No: Tuberculosis/Bronchitis | 39. <input type="checkbox"/> Yes <input type="checkbox"/> No: Frequent or severe headaches |
| 16. <input type="checkbox"/> Yes <input type="checkbox"/> No: Frequent Cold sores(herpes)/Mouth Ulcers | 40. <input type="checkbox"/> Yes <input type="checkbox"/> No: Epilepsy/Seizures/Loss consciousness |
| 17. <input type="checkbox"/> Yes <input type="checkbox"/> No: Muscle disease/Cerebral palsy | 41. <input type="checkbox"/> Yes <input type="checkbox"/> No: Alzheimer's disease/Other Dementia |
| 18. <input type="checkbox"/> Yes <input type="checkbox"/> No: Arthritis/Bone Disease | 42. <input type="checkbox"/> Yes <input type="checkbox"/> No: Spinal cord injury/Paralysis |
| 19. <input type="checkbox"/> Yes <input type="checkbox"/> No: Artificial joint replacement | 43. <input type="checkbox"/> Yes <input type="checkbox"/> No: Eye Problems/Glaucoma/Cataracts |
| 20. <input type="checkbox"/> Yes <input type="checkbox"/> No: Dialysis/Kidney failure | 44. <input type="checkbox"/> Yes <input type="checkbox"/> No: Hearing impairment |
| 21. <input type="checkbox"/> Yes <input type="checkbox"/> No: Bleeding or bruising tendency/Anemia | 45. <input type="checkbox"/> Yes <input type="checkbox"/> No: Surgery/Hospitalization in past 5 years |
| 22. <input type="checkbox"/> Yes <input type="checkbox"/> No: Hemophilia | List _____ |
| 23. <input type="checkbox"/> Yes <input type="checkbox"/> No: Blood clots/Thrombosis/Sickle cell disease | Females |
| 24. <input type="checkbox"/> Yes <input type="checkbox"/> No: Diabetes I/II | 46. <input type="checkbox"/> Yes <input type="checkbox"/> No: Are you pregnant now? Due date _____ |

47. Yes No: Are you taking birth control pills?
48. Yes No: Are you breast feeding?

49. Do you use recreation drugs Yes No Type _____ Amount/Freq _____
50. Other medical conditions not listed? _____
51. Have you ever been asked to take a Pre-Medication due to Mitral Valve Prolapse, Heart Murmur, Phen-fen or artificial joint?
YES () NO ()
52. Any other drug allergies not listed? _____
53. Do you have any foreign materials in your body? i.e. Metal plates, pins, screws, etc. () Yes () No. If so, list _____

52. Are you taking or have you ever taken any of these medications? (circle one) Phen-Fen, Fosamax, Aredia, Zometa, Actonel, Dirdronel, Skelid, Ostac, Bonefos or Boniva

I hereby authorize and consent for a dental examination, necessary x-rays and diagnosis of my oral condition. Confidentiality will be protected in the manner and to the extent allowed by state law. To the best of my knowledge, I have truthfully answered all questions about my health history and will inform my providers of any changes as they occur.

Patient/ Parent Signature: _____ Date: _____

Doctor Signature: _____ Date: _____



About our Office

- Our greatest concern is your complete oral health. Anything we do or say will be centered on that philosophy. We believe in preventive and not emergency dentistry.
- It is suggested that each patient is seen every six months (or as needed) to assure this preventive philosophy is met.
- Our time, as well as our patient's time, is valuable. Failure to show for your reserved appointment time on our schedule wastes valuable time another patient could have used. A fee will be assessed on any broken appointment where a **minimum of 48 BUSINESS hours notice** was not given.
- Dr. Coats has the utmost confidence in her staff to handle any questions regarding office policy, financial arrangements, appointments and insurance matters. Please direct any of these inquiries to our office manager.

About Insurance

- Insurance is a contract negotiated between your employer and the insurance company that does not involve your doctor. The policy outlines covered dental and medical benefits, as well as, non-covered and excluded services. It provides basic or minimal coverage that may have nothing to do with what you want or need.
- Insurance claims are filed by Becky Coats DDS, PA as a courtesy to our patients. **We will only verify your insurance coverage and eligibility 1 (one) time each year from the date you join our practice. It will be your responsibility to notify us of any changes to your coverage.**
- Becky Coats DDS, PA is not required to file insurance or track patient's insurance plan

Financial Facts

- Payment is expected the day services are rendered. Our office accepts Cash, Personal Check, MasterCard, Discover and Visa.
- Our office does offer an extended credit through an outside lender by the name of Care Credit. Depending on the amount charged you could get this at no interest to you. This is based on approved credit.
- We gladly accept your check as payment. However, in an effort not to inconvenience you in the unlikely event that these funds are dishonored, we reserve the right to collect them electronically for the face value of the check, plus an additional debit for a return check fee equal to the state's legal limit.
- **In the event that your insurance doesn't pay what the estimated portion is, you will be responsible for the entire cost of your treatment.**

I, _____ have read and understand the information above. I also understand that I am responsible for any balance that my insurance does not cover.

Signature of patient or account holder

Date



**IF YOU HAVE DENTAL BENEFITS,
HERE ARE SOME THINGS YOU SHOULD KNOW!**

We, at Grapevine Dental Care believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide OUTSTANDING dental care to all of our guests. Some have dental benefits, but most don't. If you have dental benefits, Congratulations! You are very fortunate. Here are some important things you should know...

- Your dental benefits are based upon a contract made between YOUR EMPLOYER and the INSURANCE COMPANY. If you have any questions regarding your dental benefits please contact your employer or your insurance carrier directly.
- Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of \$1,000. You'll be surprised to know that presently, the average dental benefit plan has a yearly maximum cap of \$1,000. That is \$139.00 in "today's dollars". There has been no significant increase in the yearly maximum cap in over 40 YEARS! However, dental insurance premiums have risen over 600% in that same period of time. **DENTAL BENEFIT PLANS WILL NEVER PAY FOR THE COMPLETION OF YOUR DENTAL CARE. IT IS ONLY MEANT TO ASSIST YOU.**
- Many people receive notification from their insurance company that dental fees are "above usual and customary". An insurance company determines their reimbursement (fee) level by surveying a geographical area (included in this are discounted dental clinics and managed care facilities, which have severely reduced dental fees by an additional 25%. So, an insurance companies "average, usual and customary" fee, by their own definition is much lower than the average! Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary".
- Many dental benefit plans deceptively tell their participants (YOU-the Patient) that they will cover "UP TO 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum or the limitations. It is more realistic to expect dental benefit plans to cover between 30%-60% of the dental services. **Remember that the amount a plan reimburses you is determined by how much your employer has paid for your dental benefit plan.** You will get back only what your employer has put in, less the insurance company's profit margin. If you are dissatisfied with this reimbursement, please speak with your personnel department / director, who can provide you with a proper, comprehensive dental benefit plan.
- **Insurance companies do NOT cover many routine, state of the art and/ or highly advance dental services.**

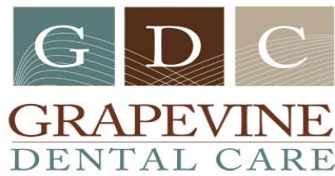
Our team members will gladly assist you in filling the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available WITH or WITHOUT dental benefits. We hope you will choose the best that dentistry has to offer.

- Your insurance is a contract between YOU, YOUR EMPLOYER and the INSURANCE CARRIER. **We are NOT a party to that contract.** If you have a problem with your insurance coverage, we ask that you speak directly to your insurance company. YOUR CHARGES IN OUR OFFICE ARE YOUR RESPONSIBILITY FROM THE DATE THE SERVICES ARE RENDERED. We DO NOT base your diagnosed treatment on your insurance coverage. We base it on your needs and desires. We take pride in the quality of care we offer our patients and make every effort to have your dental visits with us be as comfortable as possible.

*****Please read and sign even if you DON'T have dental insurance.*****

Patients Name (printed) _____ Date _____

Patients/ Guardians signature _____



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. **By signing below I consent for the use of my personal health information for treatment, payment, and operations and other uses as described in the privacy notice.** I also understand that I have the right not sign this agreement.

Print 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:

Witness Name: _____ Signature: _____

Date: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individuals office instead of the individuals home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone _____ Written Communications
 O.K. to leave message with detailed information O.K. to mail to my home
 Leave message with call-back number only O.K. to mail to my work/ office address (please list on back of this form)
 O.K. to fax to number indicated _____

Cell Number: _____ Work Number: _____
 O.K. to leave message with detailed information O.K. to leave message with detailed information
 Leave message with call-back number only Leave message with call-back number only

I allow you to give my clinical information to or answer questions from (check all that apply).

- Spouse
- Parent
- Child
- Other (specify) _____
- None

Patient signature: _____ Date: _____

Print Name: _____ Date of Birth: _____