# Patient Information

Patient's Name _____
Last First Middle

Birthdate _____ Male _____Female _____

Email Address _____

Street Address _____Apartment Number _____

City _____ State _____ Zip Code _____ How long? _____

Home Phone _____ Cell Phone _____Work Phone _____

Social Security Number _____Texas Driver's License Number _____

Where appropriate and necessary a credit bureau report will be obtained.

Spouse's Name _____ Spouse's Social Security Number _____

Spouse's Work Phone _____ Spouse's Cell Phone _____

Previous Street Address _____

Previous City _____ State _____ Zip Code _____

**DENTAL INSURANCE**

**Primary Carrier- Patient's Insurance**

Company _____ Group Number _____

Name of Insured _____ ID Number of insured _____

Insurance Company Phone _____

**Secondary Carrier**

Company _____ Group Number _____

Name of Insured _____ ID Number of Insured _____

Insurance Company Phone _____

**EMPLOYMENT**

Occupation _____ Spouse's Occupation _____

Company Name _____ Company Name _____

Address _____ Address _____

City _____ State ___ Zip_____ City_____ State ____ Zip _____

**SIGNATURE** _____ Date _____

**PATIENT PRIVACY QUESTIONNAIRE**

**PATIENT NAME:** _____

**The following questions refer to how you want the office of Marla D. Donohue, D.D.S. to handle your correspondence regarding your confidential medical information. Please complete this form, sign and date it. Your responses will be considered durable until withdrawn. You may change your responses at any time by completing a new form. For more information, please see the Notice of Privacy Policies and Practices.**

1. **Please list all family members and other persons, if any, whom we may inform about your medical condition or diagnosis:**

   _____

   _____

   _____

2. **Please list those people that we may contact ONLY IN CASE OF EMERGENCY:**

   _____

   _____

   _____

3. **Please print the address of where you would like your billing statements and other correspondence from this office sent:**

   _____

   _____

4. **Please indicate if you want all correspondence from our office marked "CONFIDENTIAL"**
   **YES** _____ **NO** _____

5. **Please provide the telephone number(s), if any, where you want to receive phone calls about your appointments, test results or other medical information:**

   _____

6. **Can confidential messages (example: appointment reminders) be left on your home answering machine, voice mail, text or email?** **YES** _____ **NO** _____

   **At your place of employment?** **YES** _____ **NO** _____

7. **May we contact your pharmacy by phone regarding prescriptions?**
   **YES** _____ **NO** _____

8. **May we send non-confidential appointment reminders (post cards) to you via USPS regular mail?** **YES** _____ **NO** _____

9. **May we communicate pertinent confidential medical information to your other treating doctors?** **YES** _____ **NO** _____

_____ _____

**Signature of Patient/Guardian (if under age 18)/Legal Custodian** **Date**

*It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionaire...*

## *DENTAL HISTORY*

How LONG SINCE you have seen a Dentist: _____

Last COMPLETE Dental Exam, Date: _____

Last FULL MOUTH X-RAYS, DATE: _____

(machine that rotates around your head, or 16 small films.)

Are you having PROBLEMS now? YES NO

Please explain _____

_____

_____

Is your present dental health POOR? YES NO

Would you like to have NITROUS OXIDE (laughing gas) treatment? YES NO

Do your gums BLEED, or feel TENDER or IRRITATED? YES NO

Are your teeth sensitive to HOT, COLD, SWEETS, PRESSURE?(circle) YES NO

Are you UNHAPPY with the APPEARANCE of your teeth? YES NO

Color? YES NO

Shape? YES NO

Do you have LOOSE, TIPPED, or SHIFTING teeth? (circle) YES NO

Name of Previous Dentist: _____

City _____ State _____

How do you feel about your teeth? _____

_____

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment . . .

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

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

## MEDICAL HISTORY

PHYSICIAN'S NAME _____ Date of last physical exam _____

Birthdate _____ Age _____

Do you have or have you had any of the following. Please indicate with check mark (✓).

| | | | |
|---|---|---|---|
| ☐ Any heart problems | ☐ HIV positive | ☐ Diabetes | ☐ Scarlet Fever |
| ☐ High blood pressure | ☐ Allergies to anesthetics | ☐ Hepatitis | ☐ Sinus Problems |
| ☐ Low blood pressure | ☐ Allergies to medicines | ☐ Herpes | ☐ Stroke |
| ☐ Circulatory problems | or drugs | ☐ Malignancies | ☐ Typhoid Fever |
| ☐ Nervous problems | ☐ Allergies to _____ | ☐ Measles | ☐ Tonsilitis |
| ☐ Radiation treatments | ☐ Anemia | ☐ Mumps | ☐ Tuberculosis |
| ☐ Excessive bleeding | ☐ Arthritis | ☐ Psychiatric care | ☐ Ulcer |
| ☐ AIDS | ☐ Asthma | ☐ Rheumatic Fever | ☐ Venereal Disease |

☐ Are you pregnant? Blood Pressure: S _____ /D _____ / _____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

_____

Names of Drugs Allergic To: _____

_____

Medication Taking Now: _____

_____

Date _____ Your signature _____

# Financial Office Policy

**Int.** _____ Payment of dental treatment is due the day services are performed. We accept debit cards, cash, Visa/MasterCard or cashiers checks. **PERSONAL CHECKS ARE NOT ACCEPTED.**

**Int.** _____ Obligation for payment belongs to the patient or person accompanying child/patient to the appointment. If you have dental insurance, we will file your claim and give you an **approximate total** for your co-payment. The co-payment estimate is due the day services are rendered. If there is a balance on the patient account after insurance is processed, we will then send a statement for the remaining balance.

**Int.** _____ There will be a **10% finance charge** for outstanding balances over 60 days.

**Int.** _____ Patients with **BLUE CROSS BLUE SHIELD INSURANCE** must make payment in full the day services are rendered and we will file the claim for you as a courtesy. The insurance company then reimburses the patient.

**Int.** _____ A fee of **50.00** is charged for **NO SHOW OR CANCELLED APPOINTMENTS THAT HAVE NOT BEEN GIVEN 24 HOURS NOTICE.**

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

# Marla D. Donohue, D.D.S.

## Acknowledgement of Receipt

Of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices. If I am a minor unaccompanied by a parent or guardian, I will accept this Notice and provide it to my parent or guardian.

_____

Please print name

_____

Signature

_____

Date

**FOR OFFICE USE ONLY**

The patient was offered a copy of the Notice of Privacy Practices. An attempt was made to obtain a signature on this Acknowledgement of Receipt for the notice. It could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Parent stated that a copy was received previously prior to treatment of sibling.
- ☐ Communications or language barrier.
- ☐ Emergency situation prevented obtaining acknowledgement.
- ☐ Other (Specify below).

_____

_____

Received by _____ Date _____

Staff Member