ARLINGTON DENTAL
Joseph Reed, DMD MAGD
821 N Fielder Rd, Arlington, Texas 76012
Ph: (817)303-5700 Fax: (817)548-7099
Email: drreedoffice@gmail.com Website: www.ArlingtonDental.com

Patient Information

Name:

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ **Gender:** ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Birth / SSN / License

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Driver License#: _____

Address: _____ Apt#_____ State: _____ Zip Code: _____

Phone:

Cell: (____) _____-_____ Home: (____) _____-_____ Work: (____) _____-_____

Best time to contact you: _____ Email: _____

For your convenience, our office can communicate with you about your health and our office by email and text message.

It's ok for our office to communicate with you by text message? **YES / NO (Circle one)**

It's ok for our office to communicate with you by email? **YES / NO (Circle one)**

RESPONSIBLE PARTY

Responsible Party refers to the person that is Financially Responsible for the patient (Guarantor).

Who is the Responsible Party (if Another, fill out the information below) ☐ Self ☐ Another Person

Continue on the next page…

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Responsible Party Information (if not yourself)

Name:

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ **Gender:** ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Birth / SSN / License

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Driver License#: _____

Address: _____ **Apt#**_____ **State:** _____ **Zip Code:** _____

Phone:

Cell: (____) _____-_____ Home: (____) _____-_____ Work: (____) _____-_____

Email: _____

Preferred Pharmacy Information

Pharmacy Name/Location: _____

Pharmacy Phone Number: (____) _____-_____

SIGN FORM

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can cause dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____

Date: _____

Medical History Form

Patient Name: _____ **Date of Birth:** _____

Disclaimer: Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

General Single Questions:

Are you under a physician's care now? Yes / No

Have you ever been hospitalized or had a major operation? Yes / No

Have you ever had a serious head or neck injury? Yes / No

Are you taking any medications, pills, or drugs? Yes / No

Do you take, or have you taken, Phen-Fen or Redux? Yes / No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes / No

Are you on a special diet? Yes / No

Do you use tobacco? Yes / No

Do you use controlled substances? Yes / No

General List Questions:

Women: Are you...

- Pregnant/Trying to get pregnant? Yes / No
- Nursing? Yes / No
- Taking oral contraceptives? Yes / No

Are you allergic to any of the following? Check all that apply.

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics
- ☐ Other? [Please specify]

_____

Medical History Form

Current Health:
Do you have, or have you had, any of the following? Check all that apply.
(Continue on the next page)

- ☐ AIDS/HIV Positive
- ☐ Cortisone Medicine
- ☐ Hemophilia
- ☐ Radiation Treatments
- ☐ Alzheimer's Disease
- ☐ Diabetes
- ☐ Hepatitis A
- ☐ Recent Weight Loss
- ☐ Anaphylaxis
- ☐ Drug Addiction
- ☐ Hepatitis B or C
- ☐ Renal Dialysis
- ☐ Anemia
- ☐ Easily Winded
- ☐ Herpes
- ☐ Rheumatic Fever
- ☐ Angina
- ☐ Emphysema
- ☐ High Blood Pressure
- ☐ Rheumatism
- ☐ Arthritis/Gout
- ☐ Epilepsy or Seizures
- ☐ High Cholesterol
- ☐ Scarlet Fever
- ☐ Artificial Heart Valve
- ☐ Excessive Bleeding
- ☐ Hives or Rash
- ☐ Shingles
- ☐ Artificial Joint
- ☐ Excessive Thirst
- ☐ Hypoglycemia
- ☐ Sickle Cell Disease
- ☐ Asthma
- ☐ Fainting Spells/Dizziness
- ☐ Irregular Heartbeat
- ☐ Sinus Trouble
- ☐ Blood Disease
- ☐ Frequent Cough
- ☐ Kidney Problems
- ☐ Spina Bifida
- ☐ Blood Transfusion
- ☐ Frequent Diarrhea
- ☐ Leukemia
- ☐ Stomach/Intestinal Disease
- ☐ Breathing Problems
- ☐ Frequent Headaches
- ☐ Liver Disease
- ☐ Stroke
- ☐ Bruise Easily
- ☐ Genital Herpes
- ☐ Low Blood Pressure
- ☐ Swelling of Limbs
- ☐ Cancer
- ☐ Glaucoma
- ☐ Lung Disease
- ☐ Thyroid Disease
- ☐ Chemotherapy
- ☐ Hay Fever
- ☐ Mitral Valve Prolapse
- ☐ Tonsillitis
- ☐ Chest Pains
- ☐ Heart Attack/Failure
- ☐ Osteoporosis
- ☐ Tuberculosis
- ☐ Cold Sores/Fever Blisters
- ☐ Heart Murmur
- ☐ Pain in Jaw Joints
- ☐ Tumors or Growths
- ☐ Congenital Heart Disorder
- ☐ Heart Pacemaker
- ☐ Parathyroid Disease
- ☐ Ulcers
- ☐ Convulsions
- ☐ Heart Trouble/Disease
- ☐ Psychiatric Care
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Medical History Form

- Have you ever had any serious illness not listed above? (if so, please specify)

_____
_____

- Please list all of the current medications you are taking if any, or you can also provide a list of your own to the front staff.

_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient`s) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____
Signature Date

Patient Dental History Form

What is your primary reason for seeking dental care? _____

Previous Dentist Information

Office/Dentist Full Name: _____

City, State and ZIP: _____

Month and Year of Last Visit: _____

What was done at your last visit? _____

Date of last Full Mouth X-rays: _____

Reason for leaving previous dentist: _____

How often do you visit the dentist? (check one)

- ☐ Annual Check Up
- ☐ Twice a Year Check Up
- ☐ Only when I have a problem
- ☐ Other _____

Please answer the following questions.

Are you nervous about receiving dental treatment?	Yes / No
Do you gag easily?	Yes / No
Have you had previous problems with dental care?	Yes / No
Are your teeth sensitive to hot, cold, pressure or sweets?	Yes / No
Do you have problems with teeth or fillings breaking?	Yes / No
Are you aware of an uncomfortable bite?	Yes / No
Do your gums feel tender and or bleed?	Yes / No
Does food catch between your teeth?	Yes / No
Have you had periodontal (gum) treatments?	Yes / No
Do you get sores in or around your mouth?	Yes / No
Do you have regular headaches, ear aches or neck pains?	Yes / No

Patient Dental History Form

Do you grind or clench your teeth?	Yes / No
Do you hear a clicking sound when you open or close your mouth?	Yes / No
Does your jaw ever get stuck?	Yes / No
Do you have a Temporomandibular (TMJ) jaw disorder?	Yes / No
Are you missing teeth that have not been replaced?	Yes / No
Have you had excessive bleeding after an extraction?	Yes / No
Do you take any Bisphosphonate medication such as Fosamax, Boniva, Actonel, Aredia or Zometa?	Yes / No
Have you had mouth sores that take long to heal?	Yes / No
Do you have any dental implants?	Yes / No
Do you wear dentures? (partials or full)	Yes / No
Do you have any crowns (caps) or bridges?	Yes / No
Do you chew tobacco?	Yes / No
Do you have a dry mouth?	Yes / No
Are you unhappy with the appearance of your teeth?	Yes / No
Would you like your smile to look better?	Yes / No
Would you like whiter teeth?	Yes / No
Would you like straighter teeth?	Yes / No
Do you regularly use dental floss?	Yes / No
Do you brush at least once daily?	Yes / No

Is there anything else that you would like us to know? Yes / No

If so, please let us know: _____

_____ (Initial) I authorize the use of my radiographs (x-rays) and or photographs for educational and promotional use in seminars, publications and the dental office website.

_____ (Initial) I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other

member of his or her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature

Date

Insurance Information

Insurance Type

Do you have dental insurance or will you be paying for yourself?

☐ I have dental insurance ☐ I will pay for myself

Primary Dental Insurance - Insurance Company

Type of plan (circle one): PPO / Medicare / Medicaid / Other

Insurance Company Name: _____

Subscriber ID/SSN: _____

Group #: _____ Employer/Group Name:

_____

Primary Dental Insurance – Insured

Relationship to Patient

☐ Self ☐ Another person, if so fill out the information below

Subscriber First Name and Last Name: _____

Birth / SSN

Date of birth: _____/_____/_____ SSN: _____-_____-_____

Secondary Dental Insurance - Insurance Company

Do you have secondary insurance you'd like to use? (circle) YES / NO

If yes, please provide a copy of your insurance card to the front desk.

Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____ **Date:** _____

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HIPAA Consent

I give my permission to Dr. Joseph Reed and any associate in his employ, including hired team members to discuss my health and dental situation/treatment with the following person(s):

Name (first and last): _____

Address: _____

City: _____ State: _____ Zip code: _____

Cell number: _____

This authorization shall be in effect from this day forward, and until I advise Dr. Joseph Reed otherwise in writing.

On this day I represent that I am over the age of 18 years, am in sound state and mind, and am competent to enter into this agreement. I am fully aware of and understand the contents of this agreement. All my questions have been answered.

This authorization is not valid for the request of printed copies of your medical records. Only you or your legal personal representative may sign a Health information Release form to obtain copies of your medical records. I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

(Initial) _____ I do not wish to list any person(s) at this time.

Signature _____

Date: _____

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Financial Office Policies

Ultimately you are responsible for payment for your treatment. You are responsible for any and all co-payments and deductibles or any lapse or change in coverage that may occur after we have verified your dental insurance. Social security numbers are needed to make any payment arrangements or appeal any unpaid insurance claims

Insurance payment will be remitted to Arlington Dental unless other written arrangements are made. Any Insurance payments mailed to you must be remitted to the office or you may pay in full at your visit.

It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit.

It is your responsibility to understand your benefit plan with regard to, for instance, covered services and excluded services, and frequency limitations. We are not responsible for exclusions or downgraded services.

Patients are expected to pay for services and co-payments in FULL at the time of the visit or sign financial arrangements for payment. Any insurance short falls or uncovered services will be billed after insurance pays and charge an annual APR of 1.5% per month. We accept Cash, Checks, Visa, American Express, MasterCard and Discover. We also accept Care Credit, Lending Club and soon to come Cherry.

If you are not able to keep an appointment, we require 48-hour notice during business hours. Missed/Canceled (short notice) Fee: $50 or 25% of the appointment fee after 1st time or medical exception is made. Balances will incur a finance charge of 1.5 % per month and balances older than 90 days without a signed Financial Arrangement will be forwarded to a collection agency. You agree to reimburse us the fees of any collection agency, which may be up to 40% of the account balance, and all costs, including attorneys' fees, we incur in such collection efforts. A $35 fee will be charged for any checks or ACH payments returned for insufficient funds and for payment arrangements that fail to process on the arranged date.

(Initial) _____ I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Signature _____

Date: _____