*18707 Hardy Oak Blvd Ste 305 San Antonio, TX 78258*
*Tel (210)888-0700 Fax (210)625-7398*
*worldpediatricdental.com*

# *Welcome!*

**Patient Information:**

Patient Name: _____ Preferred Name: _____

Birth Date: _____ Male: _____ Female: _____ Married: _____ Single: _____ Minor: Y N

SS#: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

E-mail address: _____ Best way to reach you: _____

Employer: _____

Emergency Contact: _____ Phone #: _____

Other family members seen by us: _____

How did you hear of us? _____

If referred by someone, whom may we thank for the referral? _____

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

Name: _____ Relationship to patient: _____

Birth Date: _____ SS#: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

**Dental Insurance Information (Primary):**

Policyholder's Name: _____ Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

**Dental Insurance Information (Secondary):**

Policyholder's Name: _____ Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Do you like your smile? Y N

What, if anything, would you change about your smile? _____

Why have you come to the dentist today? _____

Are you currently in pain? Y N Do your gums bleed? Y N How many times a day do you brush? _____

Do you now have or have you ever experienced pain/discomfort in your jaw (TMJ)? Y N

Have you ever had problems with previous dental treatment? Y N

If yes, please explain: _____

Previous Dentist or Dental Office: _____ When was last dental visit? _____

Do you smoke or use chewing tobacco? Y N If yes, how long? _____ How often? _____

Physician's Name: _____ Phone #: _____

Have you ever had a serious head, neck, or back injury? _____

**WOMEN:** Are you or could you be pregnant? Y N Are you nursing? Y N Taking Oral Contraceptives? Y N

**Are you currently being treated for or have you ever been treated for any of the following? Please check all that apply:**

| | | | | |
|---|---|---|---|---|
| Rheumatic Fever | Epilepsy/Seizures | Tuberculosis | Hepatitis | Low Blood Pressure |
| Heart Murmur | Diabetes | Asthma | HIV/AIDS | High Blood Pressure |
| Mitral Valve Prolapse | Glaucoma | Sinus Problems | Blood Transfusion | Heart Attack/Stroke |
| Artificial Valve/Joint | Arthritis | Cancer/Chemo | Drug/Alcohol Abuse | Pacemaker/Heart Surgery |
| Any implant/transplant | Kidney Problems | Severe Headaches | Psychiatric Care | Excessive bleeding/Bruise easily |

Please list any medical condition not listed above: _____

**Are you allergic to any of the following? PLEASE CHECK to all that apply:**

| | | | | |
|---|---|---|---|---|
| Latex | Penicillin | Aspirin | Erythromycin | Codeine |
| Tetracycline | Ibuprofen | Tylenol | Sulfa | Dental Anesthetics |

Other

_____

Please list all medications you are currently taking:

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status.

Patient Signature: _____ Date: _____

Parent/Guardian Signature **if patient is a minor**: _____ Date: _____

**Consent for Services:**

As a condition of treatment by this office, ***all financial arrangements must be made in advance.*** The practice depends upon collection from patients for the costs incurred for their care. An estimate of financial responsibility on the part of each patient will be determined before treatment.

All emergency dental services, or any dental services performed without previous arrangements, must be paid for at the time of service.

Any treatment recommendations are made based on what is best for you, our patient; treatment is not recommended based on what will or will not be covered by your insurance. As a courtesy, we will bill your dental insurance for services rendered. We will do our best to give you an accurate estimation for what will be paid by your dental insurance, but we cannot guarantee what they will pay. ***It is our office policy to collect patient's estimated portion at the time of service***.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. An annual percentage rate of 18% will be applied monthly to any balance not paid within 60 days, unless written financial arrangements have been established.

I have read and understand the above conditions of treatment and payment; I agree and give my consent for treatment.

**Signature: _____ Date: _____**

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**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY:**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect October 1 2014, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. You may contact us to request more information about our privacy practices.

**USES AND DISCLOSURES OF HEALTH INFORMATION:**

We use and disclose health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use or disclose your health information to obtain payment for services we provide you. We may use and disclose your health information with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications certification, licensing or credentialing activities.

**Signature: _____ Date: _____**

**Submit Form**