4262 Highway 66, Caddo Mills TX. 75135 (903) 527-9292

Today's Date: _____ |□ M □ F| □Married □Single □Partnered □Separated □Widowed

Patient Name:_____
Last First Middle

Goes by/Nickname_____ Age: _____ DOB: _____

Address: _____
Street address / RR / Box # City State Zip

Driver's License #:_____ SSN: _____

Home Phone: _____ Cell Phone: _____

Employer: _____Work Phone: _____

Email Address: _____-

Ok to contact via email? □ YES □ NO Ok to contact via text? □ YES □ NO

Spouse/Parent Information

Name: _____ DOB: _____
Last First Middle Initial

Address: _____
Street address / RR / Box # City State Zip

License #:_____ SSN: _____

Home Phone: _____ Cell Phone: _____

Employer: _____Work Phone: _____

Email Address: _____ - Ok to contact via email? □ YES □ NO

Other family members seen by us:_____

EMERGENCY CONTACT Not Living with You**:** _____Relation:_____

Home #_____ Cell # _____ Address_____

How did you hear about us?

□ Drive by □ Website □ Facebook□ Billboard □ Event □ Tooth Fairy □ Christmas Parade

□ Patient: _____

Insurance Information

Insurance Name _____ INS Co. Phone # _____

Insurance Co. Address:_____

Employer Name: _____Group #:_____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder ID/SS# _____ Do you have Secondary Insurance □ YES □ NO

Health Information:

Reason for visit _____ Are you in pain □ YES □ NO

When was your last dental visit dentist? _____ Did you have x-rays □ YES □ NO

Who was your previous dentist? _____ Do you floss daily? □ YES □ NO

Do you brush daily? □ YES □ NO Do your gums bleed? □ YES □ NO

Do you require antibiotics before dental treatment? □ YES □ NO

Have you ever had periodontal disease? □ YES□ NO Are your teeth sensitive? □ YES □ NO

General/Doctor: _____ Date of Last Visit: _____

Dr.'s City, State: _____ Phone #: _____

Are you allergic to any of the following?

□ Aspirin
□ Barbiturates
□ Codeine
□ Dental Anesthetics
□ Erythromycin
□ Jewelry/Metals
□ Latex
□ Penicillin
□ Sedatives
□ Sulfa Drugs
□ Tetracycline
□ Other

Please list additional drugs/materials that cause allergic reactions:

_____

Please **CHECK** if you <u>have ever been treated</u> for any of the following:

□ Abnormal Bleeding
□ AIDS/HIV
□ Alcohol Abuse
□ Anemia
□ Arthritis
□ Artificial Bones/Joints
□ Artificial Valves
□ Asthma
□ Autism/Aspergers
□ Bleeding/Transfusions
□ Cancer/Tumors
□ Cerebral Palsy
□ Chemotheraphy
□ Chicken Pox
□ Cleft lip/Palate
□ Colitis
□ Congenital Heart Defect
□ Diabetes
□ Difficulty Breathing
□ Drug Abuse
□ Emphysema
□ Epilepsy
□ Fainting Spells
□ Hay Fever
□ Heart Attack
□ Heart Disease
□ Heart Murmur
□ Heart Surgery
□ Hepatitis (Type) _____
□ High Blood Pressure
□ Kidney Disease
□ Liver/GI Disease
□ Low Blood Pressure
□ Lupus
□ Mitral Valve Prolapse
□ Osteoporosis
□ Pacemaker
□ Persistent Cough
□ Psychiatric Problems
□ Radiation Treatment
□ Recurring Headaches
□ Rheumatic Fever
□ Scarlet Fever
□ Seizures/Convulsions
□ Sinus Problems
□ Stroke
□ Thyroid Problems
□ Tonsillitis
□ Ulcers
□ **None of the above**

Please explain any items checked above: ____

____

Do you have any of the following habits? □ Thumb/Finger/Lip Sucking □ Pacifier □ Tongue Thrusting □ Grinding

Are you taking any of the following?

□ Acetaminophen
□ Antibiotics
□ Antihistamines
□ Aspirin
□ Blood Thinners
□ Blood Pressure Medication
□ Cold Remedies
□ Digitalis/Heart Medication
□ Insulin/Diabetes Drugs
□ Nitroglycerin
□ Recreational Drugs
□ Steroids/Cortisone
□ Thyroid Medicine
□ Tranquilizers

Are you currently taking any prescription, over the counter drugs, herbal remedies, vitamins or mineral not listed above? □ YES □ NO

Women

Are you taking birth control □ YES □ NO Are you pregnant □ YES □ NO Week # _________

Are you nursing □ YES □ NO

PRIVACY STATEMENT

This office will not release any information about our patients except to parents, legal guardians, your insurance carrier, or to other referred medical or dental offices, except by court order.
Carole Bates, D.D.S.

Acknowledgment of Receipt of Notice of Privacy Practices

(You may refuse to sign this acknowledgement)

I have read and understand the above statement and a copy of this office's Notice of Privacy Practices has been made available to me.

______________________________ ______________________
Signature Date

____
Printed Name

°°

◇ FINANCIAL RESPONSIBILITY ◇

I assume financial responsibility for all dental treatment and medications provided for my myself/child(ren), and understand that payment is expected on the date services are provided. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions and authorize direct payment to Caddo Mills Dental for dental benefits otherwise payable to me**. I understand that my dental insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered.**

I have read and understand the above statement and a copy of this office's Notice of Privacy Practices has been made available to me.

______________________________ ______________________
Signature Date

◇ CANCELLATION POLICY ◇

In order to serve our patients better, we have instituted a cancellation policy. If you cannot make it to your appointment please contact us 24 hours in advance to cancel or reschedule. Failure to keep your appointment causes an inconvenience to our staff, and deprives other patients of the opportunity for that appointment time. Additionally, being late for an appointment causes all following appointments to be late as well. It is for this reason and with respect for our patients, that **your appointment will be considered "missed" if you are ten or more minutes late. We only have a select amount of appointments daily to take care of our patients. There will be a $55 charge for missed or short notice cancellations. Also a dismissal of a patient if you do not come to our appointment/no show 3 times.**

◇ ACKNOWLEDGEMENT ◇

I, _____ have read, understand, and agree to abide by all of the above statements. Furthermore, I affirm that the information contained in these forms is correct and I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility, and I hereby agree, to inform this dental office of any changes in my health status, insurance information and/or contact information. Finally, all authorizations contained herein will remain in effect until cancelled by me in writing.

_____ _____

Signature Date

_____

Printed Name

Informed Consent for

Nitrous Oxide-Oxygen Inhalation

and/or

Internal Sedation

To help lower your anxieties about dental treatment and make the appointment more pleasant for you. The use of nitrous oxide-oxygen (laughing gas) sedation and/or internal sedation to local anesthesia. In rare cases, patients may have problems despite our best efforts. These problems include but are not limited to feeling sick to your stomach or throwing up, allergic reactions, breathing problems, and blood pressure problems. On very rare occasions patients have had to be hospitalized with a life-threatening problem.

FEMALES: if you suspect or know that you are pregnant, it is important that you tell us this, right now. There is a possible risk to your unborn baby which we need to explain to you, and also a higher risk for sudden miscarriage or loss of the baby.

We believe the need for the nitrous oxide-oxygen inhalation and / or internal sedation outweighs the risk of not providing it.

I have read the above and was given the chance to ask more questions. I freely give my informed consent for the use of this sedation during the dental procedures. I understand that no guarantees are made regarding any medical or mental results associated with the technique.

Date: _____ Signature: _____

◇ AUTHORIZATION FOR DENTAL EXAMINATION & TREATMENT OF A MINOR ◇

I am the parent or guardian who is/are (a) minor child(ren), and I do hereby authorize and consent to any x-rays, examinations, anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect supervision of Dr. Carole Bates, D.D.S.,, staff members, or agents, as he/she may deem necessary. I authorize the dental staff at Farmersville Dental to perform any and all treatments for my above named child(ren) and consent to such methods, drugs, and agents as may be indicated in connection with his or her dental care.

I authorize the following people to bring my child to Caddo Mills Dental for treatment:

Name: **DOB:** **Relationship to Patient:**

Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request dental or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Carole L Bates DDS, PA to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

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