PATIENT INFORMATION

Patient Name (First) _____ Last _____ M.I. ____ Date _____

Status (*Mark with an X*) ❑ Child ❑ Single ❑ Married ❑ Divorced ❑ Widowed Sex ❑ M ❑ F

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Date of Birth ___ /___ /___ Age _____ Soc Sec # ____ ____ _____ Driver's License # _____

To contact you in a timely manner, which method is best? ❑ Phone ❑ Email ❑ Text Message

May we contact you at work? ❑ Yes ❑ No Email _____

ADULT PATIENT

Name of Employer _____ Your Occupation _____

Name of Spouse _____ Cell Phone (____) _____ Work Phone (____) _____

Spouse's Employer _____ Occupation _____ Soc Sec # ____ ____ _____

MINOR PATIENT INFORMATION

Father's Name _____

Addr. *(if different than above)* _____

Home# _____ Work# _____ Cell# _____

Father's Employer _____

Mother's Name _____

Addr. *(if different than above)* _____

Home# _____ Work# _____ Cell# _____

Mother's Employer _____

RESPONSIBLE PARTY

Name of Person responsible for Account: First _____ Last _____ M.I. ____

Addr.*(if different than above)* _____ City _____ State _____ Zip _____

Home# _____ Work# _____ Cell# _____ Relationship to Patient: _____

Date of Birth: ___ /___ /___ Age: _____ Soc Sec # ____ ____ _____ Driver's License # _____

DENTAL INSURANCE INFORMATION

Insurance Policy Holder: _____

Policy Holder Relationship to Patient ❑ Self ❑ Spouse ❑ Parent

Employer: _____ Dental Insurance Co. _____

SS # or ID# _____ DOB: ___ /___ /___ Ins Tel # _____ Group # _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

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

HOW DID YOU HEAR ABOUT US?

❑ YP.com ❑ Google ❑ Insurance Listing ❑ Website ❑ Other _____

❑ Friend or Family Member Whom may we thank for referring you _____

METHOD OF PAYMENT

❑ Cash $ _____ ❑ Check # _____ ❑ Credit Card ❑ Care Credit

Patient Signature *(Parent signature if minor)* _____ **Date**: _____

Purpose of today's visit? _____

Are you having any pain? ❑ No ❑ Yes Location? _____ How long? _____

Date of last dental visit? _____ Last cleaning? _____ Last X-Ray? _____

Do you need to take antibiotics before dental tratment? ❑ No ❑ Yes Why? _____

DENTAL HISTORY

Check (x) if you have any of the following:

Sensitivity to: ❑ Hot ❑ Cold ❑ Sweets ❑ Chewing

Pain: ❑ Jaw ❑ TMJ ❑ Tooth ❑ Gums

❑ Clench your teeth ❑ Grind your teeth

❑ Bleeding gums ❑ Bad breath

❑ Loose Teeth ❑ Broken Teeth ❑ Cavities

❑ Broken Fillings ❑ Old Filings

❑ Old Crown *(over 10 yrs old)* ❑ Stained/discolored teeth

❑ Chew Tobacco ❑ Smoke Tobacco

❑ Snore ❑ Sleep Apnea

❑ History of Acid Reflux ❑ Severe Vomiting

❑ History of Cold sores ❑ History of oral cancer

❑ Thumb sucking habit ❑ Tongue thrusting habit

Do you want to replace missing teeth ❑ Yes ❑ No

Would you like to change the appearance of your teeth?

❑ No ❑ Yes, if so, please describe: _____

Would you like to whiten your teeth? ❑ Yes ❑ No

Have you whitened your teeth in the past? ❑ Yes ❑ No

Have you had any injury or surgery to you face or jaw?

❑ No ❑ Yes, if so, please describe: _____

Do you wear Dentures/partials? ❑ Yes ❑ No

How old are they? _____

Have you ever had gum surgery? ❑ Yes ❑ No

Describe _____

Have you ever had orthodontics (braces)? ❑ Yes ❑ No

Do you participate in sports where a mouth guard would be helpful? ❑ Yes ❑ No

Do you wear a nightguard? ❑ Yes ❑ No

Are you fearful about dental treartments? ❑ Yes ❑ No

Would you consider using:

Nitrous Oxide (laughing gas) ❑ Yes ❑ No

Sedative pill to relax you? ❑ Yes ❑ No

Describe any past bad experiences that you had in a Dental Office. _____

MEDICAL HISTORY

Check (x) if you have any of the following:

Heart Problems: ❑ Surgery ❑ Pacemaker ❑ Angina

❑ Heart Stint ❑ Heart Attack ❑ Murmur ❑ Chest Pain

❑ Mitral Valve Prolapse ❑ Rheumatic Fever

❑ Artificial Heart Valve ❑ Irregular Beat

❑ Other: _____

Lung Problems: ❑ TB ❑ Emphysema ❑ Asthma

Liver Problems: ❑ Cirrhosis ❑ Hepatitis

Artificial Joints: ❑ Hip ❑ Knee ❑ Other

❑ High Blood Pressure	❑ Stomach Ulcers
❑ Diabetes	❑ Thyroid Disease
❑ Seizures	❑ Glaucoma
❑ Stroke	❑ Vision Problems
❑ Kidney Disease	❑ Hearing Problems
❑ Hemophilia	❑ Bleeding Problems
❑ Cancer	❑ Alcoholism
❑ Radiation Therapy	❑ Drug abuse
❑ Chemotherapy	❑ Psychiatric Disorders
❑ HIV+ / AIDS	❑ Back Pain
❑ Behavior-Disorder	❑ Neck Pain

Do you have any disease or condition not listed? ❑ Yes ❑ No

Please describe _____

When was your last physical exam? _____

Are you now, or have you been:

1. Under a doctor's care? ❑ Yes ❑ No

   Why? _____

   Physician's Name _____

2. Hospitalized in the past 2 years ❑ Yes ❑ No

   Why? _____

Are you taking any medications? ❑ Yes ❑ No

List all medications you are taking. _____

Is there anything else you would like to discuss with Dr. Lane? _____

Are you allergic to any drugs ❑ Yes ❑ No: ❑ Aspirin ❑ Penicillin ❑ Codine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetic ❑ Other _____

Women: pregnant/trying to get pregnant? ❑ Yes ❑ No Nursing ❑ Yes ❑ No Oral contraceptives ❑ Yes ❑ No

How many months _____

I certify this medical history to be accurate to the best of my knowledge.

Patient Signature *(Parent signature if minor)* _____ **Date**: _____

HOLLY LANE, D.D.S
14400 Jones Maltsberger Rd # 101
San Antonio, TX
78247
(210) 545-3929

CONSENT FOR TREATMENT

I authorize Holly Lane, D.D.S. and/or her associate(s) to perform procedures including, but not limited to, prophylaxis (cleaning), x-rays, administering anesthetics and/or medication, restoring (filling) teeth, endodontic (root canal) therapy, and other procedures she may deem necessary for my care.

Signature_____ Date _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Holly Lane, D.D.S., may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). Please refer to Holly Lane, D.D.S Notice of Privacy Practices for a more complete description of such uses and disclosures. I understand I have the right to review the Notice of Privacy Practices at anytime.

By signing this form, I am consenting to Holly Lane, D.D.S use and disclosure of my PHI (Protected Health Information) to carry out TPO (Treatment, Payment, and Healthcare Operations). I understand that I may be asked for my DOB, SSN, and Texas Driver's License for identification at the time of service.

I may revoke my consent in writing, except to the extent that Holly Lane, D.D.S., has already made disclosures in reliance upon my prior consent or as required by law. If I do not sign this consent, Holly Lane, D.D.S., may decline to provide treatment to me.

PERMISSION TO DISCUSS

I also give permission for my Protected Health information (PHI) to be discussed with the following **list of people**:

_____

Signature of Patient or Legal Guardian _____

Patient's Printed Name _____
Date _____

ALL PATIENTS PLEASE READ AND SIGN BELOW

Welcome to our office. After your exam, we will discuss treatment options and the fees involved. Full payment for our services is due at the time of service, unless other mutually agreed upon arrangements are made with our office staff. We accept cash, check and VISA/MASTERCARD/DISCOVER/AMEX and ask that you pay your portion on the date of service. **Any fees associated with attempts to collect on your past due account become your responsibility. Any unpaid balance after sixty (60) days may be assed a 1.5% interest fee per month.**

Note about your appointment:
The undersigned patient agrees to provide at least **48 hours** advance notice when unable to keep a scheduled appointment. This is necessary for the convenience of other patients needing your appointment time. **We reserve the right to charge $25.00 cancellation fee for short notice cancellations.**

_____ Date _____
Signature of Patient, Parent, Legal Guardian

PATIENTS WITH DENTAL INSURANCE BENEFITS

Please read and sign below

Once insurance benefits have been verified, we will accept assignment of benefits providing you understand and agree to the following:

1. You will be asked to **pay your deductible and estimated portion** of the charges the date of service.
2. Your **exact share will not be known until final payment is received** from your insurance company. We provide **estimations only.**
3. **We will bill you for any charges your insurance refuses to pay.**
4. Your insurance is a contract between you, your employer and the insurance company. **We will not be involved in disputes between you and your insurer** regarding deductible, co-payments, covered charges, secondary, "usual and customary" charges, etc. Any fees associated with attempts to collect on your past due account become your responsibility.
5. State law requires insurance companies to pay within 30 days of being submitted. **If your insurance company has not paid your claim within 60 days, then all charges become due from you.** Any unpaid balance after 60 days may be **assessed a 1.5% fee per month.** We will assist you in dealing with the insurance company but, the ultimate responsibility lies with you.
6. If there are question about an insurance payment and any bills sent to you, we recommend that you do the following: Request a printout of your account and compare it with the insurance explanation of benefits , telephone your insurance company or call our bookkeeper to discuss your bill.

- The more you know and understand about your insurance plan the better our relationship will be.
- Please realize we deal with hundreds of plans and **cannot tell you specifics** about your plan.
- If you want more information we suggest the following:
  1. Read your insurance handbook or telephone your insurance company.
  2. Request a predetermination of benefits - **$20.00 handling fee required.**
- By contacting your insurance company, you will understand that they will not commit to you or us on an exact dollar amount until the claim has been processed by them.

_____ _____
Signature of Patient, Parent, Legal Guardian Date

Assignment of Insurance Benefits:
The undersigned patient authorizes the release of all information relating to their treatment, including x-rays, to health service plans and insurance companies. The undersigned patient requests and **authorizes their insurance company to pay directly to the doctor** the amount due on their claim for services rendered to themselves or their dependents. The undersigned agrees to be **financially responsible for any charges not covered by the insurance benefits or that are not paid within 60 days** of having treatment rendered.

Signature of Patient, Parent, Legal Guardian_____ Date_____