Patient Information

Date: ____________ Drivers License #: ______________ Pharmacy Name ____________________ #___________

Name: ______________________________________ Nickname: ________________ SS#: ____________

Date of Birth: ________________ Married _____ Single _____ Child_____

Cell Phone # ________________ Work #________________ Home # ___________________

E-Mail Address: ____

May we contact you by e-mail regarding your appointments and treatment. Y N

Street Address: ____ **Apt.#:** ______________

City: ______________________________________ **State:** ______________ **Zip:** ________________

Employed By: ____ **Since:** ______________

Health Information

Have you had or do you have any of the following? (Please circle those that apply)

Anemia	Diabetes	Hepatitis A/B/C/D/E/G	Transplant/Prostheses
AIDS (HIV) Positive	Epilepsy	High Blood Pressure	Rheumatic Fever
Arthritis/Rheumatism	Glaucoma	Joint Replacement	Recent Surgeries
Asthma	Heart Disease	Pacemaker	Tuberculosis
Cold Sores	Heart Murmur	Radiation Treatment	Chemical Dependency

Do you have any metal allergies? Yes No

Are you anxious about your appointment? Yes No

Are you pregnant? Yes No Due Date:

DO YOU HAVE ANY DRUG ALLERGIES? Yes No

If yes, Please List

Have you ever had any complications or allergic reactions following dental treatment? Yes No

If yes, please explain:

Do you currently use tobacco? Yes No If so, how long? __________

Name of Physician? ____ Phone: ______________

Are you presently taking any medications, (including birth control)? Yes No

Please list: ____

Are you presently being treated for any disease, condition or problem not listed? Yes No

If Yes please explain: ____

Previous Dentist: ____________________________________ Date of last dental visit: __________

Are you interested in whitening your teeth? Yes No

Chief concern about your oral health..____

Do your teeth / gums bleed when you brush? Yes No

Do you experience dry mouth? Yes No

Do you ever have a bad taste in your mouth? Yes No

Have you been treated for Periodontal Disease? Yes No

Are you interested in clear braces or other orthodontics? Yes No

Have you been treated for TMJ? Yes No

Would you be interested in Botox treatments ? Yes No

Howard Family Dental

Cancellation Policy

The time set aside for the doctor is unique to you. No other patient will be scheduled during this time. Therefore, this office cannot accept cancellations. You must give your doctor 48 hours notice to avoid a $35.00 cancellation fee.

Scheduling Policy

20% of the treatment fee is due at scheduling. The fee will be applied towards the total treatment.

____

Signature Date

Insurance Information

Name of Insured: ________________________ is insured a patient: Yes No
Insured's Birth Date: __________ Social Security # ____________________
Insured's Employer: ____
Patient's relationship to insured: ____________________________________
Dental Ins. Carrier Name: ______________________ Phone # ___________
Dental Ins. Add: ____
City __________________ State ______ Zip_______________
Group #___________________________

- Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Dr. Meilin Howard of the group insurance benefits otherwise payable to me.

  Signature: ____ Date: _____________

Your initial visit and routine hygiene services are to be paid at the time of service. Ins. Will be filed to reimburse you.

SECONDARY INSURANCE IS THE RESPONSIBILITY OF THE PATIENT

CONSENT FOR SERVICES

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

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will apply any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability but the patient agrees that this is an estimate only, not a guarantee of coverage.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

_______________________________________ ______ ____________________

Signature of parent or guardian **Date** **relationship** to Patient

Patient Consent Form

Meilin Howard D.D.S.
4900 Overton Ridge Blvd., Suite 109, Fort Worth, TX 76132

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this can and will be used, but is not mandatory for me to sign in order to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Prac*tices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to tine and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:____________________ Date:____________________

Signature: ____________________

Relationship to Patient:____________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:________________Initials:________________Reason:____________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, (please print)____________________, have received a copy of this office's Notice of Privacy Practices.

Signature: ____________________ Date: ____________________

OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained:

Date: ________________Initials: ________________Reason: ____________________