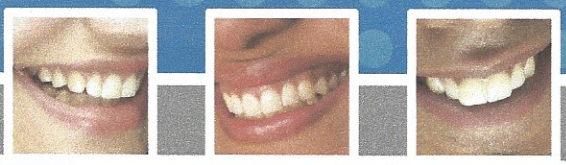
Piney Woods Family Dentistry
515 N Van Buren
Mt. Pleasant, TX 75455

(903)572-7502

www.pineywoodsfamilydentistry.com



Welcome to our Practice

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____
_____ (City) _____ (State) _____ (Zip Code)

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____
_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

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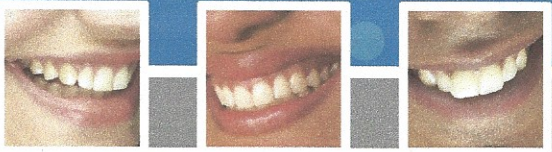

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____ _____

City State Zip Code

Insurance Authorization:

☐ By checking this box,
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

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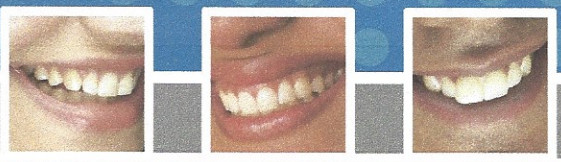

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

Please list any medications that you are currently taking:

*

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Allergies
☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Hay Fever
☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Diabetes	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting/ dizziness	☐ Glaucoma	☐ Head Injuries
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ HIV	☐ Jaundice	☐ Kidney Disease	☐ Liver Disease
☐ Mental Disorders	☐ Nervous Disorders	☐ Other	☐ Pacemaker
☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

☐ Ever been hospitalized (illness or injury)

☐ Presently being treated for any other illnesses

Signature: _____ Date: _____

If any condition or alerts selected above needs further clarification, please explain below:

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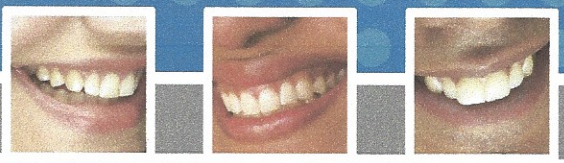

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of physician and their specialty:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

* ☐ By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long you have been a patient there:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

By signing, I understand the information is correct, accurate and agree with its contents.

Signature: _____ Date:

Response Date:

OFFICE FINANCIAL POLICY & CANCELLATION POLICY

Thank you for choosing Piney Woods Family Dentistry for your dental care. Our primary mission is to deliver the best and most comprehensive dental treatment available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- Convenient Monthly Payment Options from CareCredit and Lending Club (subject to individual credit application)
  - ✓ Allows you to pay over time
  - ✓ Online auto draft available through your online CareCredit or Account
  - ✓ No annual fees or pre-payment penalties

At the time of scheduling procedures greater than $500, patients are **required** to make a minimum 50% initial payment toward the **estimated** charges, with the remaining balance due at the time of procedure. This amount will be based on our fees, or insurance fees and benefits. Patient will be responsible for the outstanding balance that is not fully covered by insurance. Giving us dental and/or medical insurance information gives us permission to file the insurance for the services provided. If insurance is not to be billed, notify us prior to the procedure. **For patients with dental insurance, we take payment of your estimated portion in full, and then courtesy file the insurance for you.** If care is discontinued before treatment is complete, refunds will be determined upon review of the case. There will be a $30 charge for returned checks. We ask that you make every effort to keep your appointments. If we do not receive a cancellation notice from you within 24 hours of your appointment, **we will assess a $25 fee for hygiene appointments and $75 fee for treatment appointments**. If you are more than **15 minutes late** for your appointment, we may have to reschedule you to be courteous to our other, scheduled patients. For patients who miss or cancel their appointments without 72 hour notice, the office will allow the patient to reschedule with the understanding that a 50% deposit is required and is non-refundable if the appointment is canceled a second time without 24 hour notice.

HIPAA & AUTHORIZATION TO RELEASE INFORMATION

It is the policy of our office to maintain the privacy of all patient information and transactions. We are hereby authorized to release any dental, medical or incidental information that may be necessary for either dental or medical care or in the processing requests for financial benefit. A copy of our Privacy Policy is available for your review upon request.

CONSENT FOR LABORATORY TESTING

In the event that any of the office staff is injured while performing patient treatment (i.e. needle stick, puncture wound, etc.), we have your full consent to draw blood for the purpose of laboratory testing. This will ensure the safety of all parties involved.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate and authorize Dr. Niki Latiolais to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners.

By signing your name, you are verifying that you have read and agree to the information in this document.

_____ _____

Printed Name Date

_____

Signature