Patient Information (Confidential)

○ **Patient & Responsible Party (Not Policy Holder)** ○ **Primary Insurance Policy Holder**

***SECONDARY INSURANCE - NOT ACCEPTED & PATIENT WILL BE RESPONSIBLE FILE INS. CLAIM**

Subscriber - Policy Holder Information

First Name ______________________________Last Name ___________________________ Middle Initial__________

Address ___________________________City _______________ State ______________ Zip_____________________

Date of Birth _______________ Social Security#_________________

Employer's Name:____ Phone Number #: (_____)________---__________

Subscribers Dependents Information

First Name ______________________________Last Name ___________________________ Middle Initial__________

Address ________________________________ City _______________________ State _________ Zip___________

Home Phone _____________________ Cell Phone _______________________Work Phone ____________________

Date of Birth _______________Age __________Social Security________________ Driver's License# _____________

Sex ○ Male ○ Female

Check Appropriate Box: ○ Minor ○Single ○ Married ○Divorced ○ Widowed ○ Separated

Email Address: ____

○ I would like to receive correspondence via email.

○ I would like to receive correspondence via text.

For your convenience, we offer the following methods of payment:

Please check the option you prefer. Payment is required in full at each appointment.

○ Cash Credit Cards: ○Visa ○MasterCard ○ American Express/Discover ○FSA ○ Care Credit

Employer Name, Status, Referred By, Previous Dentist and Emergency Contact

Employment Status ○ Full Time ○ Part Time ○ Retired

Student Status ○ Full Time ○ Part Time

Referred By? Person, Mailer, Door hanger, Driving By or other? ____

Prev. Dentist __________________________ City ___________________________ Phone ______________________

Emergency Contact ____________________________Phone # _____________________________

Primary Insurance Information

Insurance Company Name(Ex. Delta, Aetna, Metlife, Cigna, Humana, etc) ________________________________

Ins. Address___________________________ City ________________State____________ Zip code ____________

Relationship to Insured: ○ Self ○Spouse ○ Child ○ Other

Subscriber ID#__________________________ Group Number# ________________________

Insured Soc. Security #_____________________ **Insured Date of Birth** ________________

Name of Employer __________________________________Work Phone ________________

How much is your deductible? ____________How much have you used? ________________Max. Annual ____________

Patient Name:____________________ Date:_________________________

Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No Physician Name: ________________________________

Office Phone # ____________________________ Date of Last Exam: _________________________________

Have you ever been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No Explain:____________

Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: ______________________

Are you taking any medication(s) including non-prescription? ○ Yes ○ No

If yes, what medication(s) are you taking? Please list: ____

Have you ever taken Phen-Fen or Redux? ○ Yes ○ No ____

Have you taken Boniva, Actonel or any Cancer Medications containing bisphosphonates? ○ Yes ○ No

If yes, what medication(s) are you taking? ____

Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? ○ Yes ○ No _______________________

Are you on a special diet? ○ Yes ○ No ____

Do you use tobacco? ○ Yes ○ No ____

Do you use controlled substances(Rx)? ○ Yes ○ No ____

Women ONLY: Are you pregnant/Trying**?** ○ Yes ○ No Taking Oral Contraceptives? ○ Yes ○ No
Are you Nursing? ○ Yes ○ No

Are you allergic to any of the following? Please circle the one that applies to you:

○ **NONE** ○ Aspirin ○ Penicillin ○ Codeine ○ Local Anesthetics(e.g.Novacaine) ○ Acrylic ○ Latex
○ Sulfa ○ Metal(e.g nickel,mercury,etc) ○ Other Drug not listed? Explain:____________________

Do you have, or have you had, any of the following? Please circle Yes or No.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	○	○	Cortisone Medicine	○	○	Hepatitis A	○	○	Rheumatism	○	○
Alzheimer's Disease	○	○	Diabetes	○	○	Hepatitis B or C	○	○	Scarlet Fever	○	○
Anaphylaxis	○	○	Drug Addiction	○	○	High Blood Pressure	○	○	Shingles	○	○
Anemia	○	○	Easily Winded	○	○	Hives or Rash	○	○	Sickle Cell Disease	○	○
Angina	○	○	Emphysema	○	○	Hypoglycemia	○	○	Sinus Trouble	○	○
Arthritis/Gout	○	○	Epilepsy/Seizures	○	○	Irregular Heartbeat	○	○	Spina Bifida	○	○
Artificial Heart Valve	○	○	Excessive Bleeding	○	○	Kidney Problems	○	○	Stomach/Intestinal Dis.	○	○
Artificial Joint	○	○	Excessive Thirst	○	○	Leukemia	○	○	Stroke	○	○
Asthma	○	○	Fainting Spells/Dizziness	○	○	Liver Disease	○	○	Swelling of Limbs	○	○
Blood Disease	○	○	Frequent Cough	○	○	Low Blood Pressure	○	○	Thyroid Disease	○	○
Blood Transfusion	○	○	Frequent Diarrhea	○	○	Lung Disease	○	○	Tonsillitis	○	○
Breathing Problem	○	○	Frequent Headaches	○	○	Mitral Valve Prolapse	○	○	Tuberculosis	○	○
Bruise Easily	○	○	Genital Herpes	○	○	Osteoporosis	○	○	Tumors or Growths	○	○
Cancer	○	○	Glaucoma	○	○	Pain in Jaw Joints	○	○	Ulcers	○	○
Chemotherapy	○	○	Hay Fever	○	○	Parathyroid Disease	○	○	Venereal Disease	○	○
Chest Pains	○	○	Heart Attack/Failure	○	○	Psychiatric Care	○	○	Yellow Jaundice	○	○
Cold Sores/Fever Blisters	○	○	Heart Murmur	○	○	Radiation Treatments	○	○			
Congenital Heart Disorder	○	○	Heart Pace Maker	○	○	Recent Weight Loss	○	○			
Convulsions	○	○	Heart Trouble/Disease	○	○	Renal Dialysis	○	○			
Cholesterol(High)	○	○	Hemophilia	○	○	Rheumatic Fever	○	○			

Have you ever had any serious illness not listed above? Yes or No?
If yes, please explain:____

___________________________________ ______________________________
Signature of patient (or parent/guardian if minor) Date

___________________________________ ______________________________
Relationship to Patient (If minor) Date

___________________________________ ______________________________
Doctors Signature Date

Do you have, or have you had, any of the following?

Please cross/mark Yes or No below.

	Yes or No			**Yes or No**	
Do you have frequent headaches?	O	O	Do you clench or grind your teeth?	O	O
Do you bite your lips or cheeks frequently?	O	O	Have you ever had any difficult extractions in the past?	O	O
Have you had any orthodontic treatment?	O	O	Do you wear dentures or partials?	O	O
Do your gums bleed while brushing/flossing?	O	O	Are your teeth sensitive to hot or cold liquids/foods	O	O
Are your teeth sensitive to sweet/sour foods?	O	O	Do you feel pain to any of your teeth?	O	O
Difficulty in opening or closing?	O	O	Difficulty in chewing?	O	O

	Yes or No	
Have you ever experienced any problems with your jaw?	O	O
Do you have any sores or lumps in or near your mouth?	O	O
Have you ever received oral hygiene instructions regarding the care of your teeth/gums?	O	O
Do you like your smile?	O	O

Doctor's Comments:____

____

____

____

Chris Capehart, D.D.S.
850 W. Valley Ridge Blvd., Ste 112
Lewisville, TX 75077
T (972) 436-1325

CAPEHART DENTAL - NO SHOW POLICY

Effective as of July 30, 2012.

Patient appointments in our dental office are limited, and we must reserve them for those who are able to show up for their scheduled appointment times. Therefore, we have adopted a firm "No-Show Policy" in order to minimize the number of failed appointments. This policy will be enforced as follows:

1. Cancellations must be made at least 48 hours ahead of your appointment time to avoid having a "No-Show charge" of $ 50.00 for each incident.

2. If 2 (TWO) "No-Shows" occur within a 6-month time period, the client will no longer be given appointments for their care in our office; and a referral will be made to another dental office.

3. The client will be seen for emergency care only, and only on a walk-in-and-wait basis.

We have found that it is in the best interest of our staff members and patients to adopt this policy.

I understand Capehart Dental No Show Policy as stated above:

Patient Name: ______________________________Date__________

E-MAIL RELEASE FORM

Chris Capehart, D.D.S.
850 W. Valley Ridge Blvd., Ste # 112
Lewisville, TX 75077
T (972) 436-1325

Date:_____/________/___________

I, ____ (Patient's Name, Last Name or Patient's Representative)

want to communicate via e-mail with (**CAPEHART DENTAL**)

on matters related to my dental appointment reminders, health and /or my medical treatment. I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail.

I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

Signature: ____

(Signature of Patient or Patient's Representative)

Witnessed by: _____Gaby H.(Front Desk Coordinator)_____________________________________

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Assignment of Benefits Agreement

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.
- We require you to pay the **estimated copayment**, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an **estimate** of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will responsible for paying the full amount at that time.
- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNEMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

______________________________________ __________________

Name of Patient/Responsible Party Date