Whitley Family Dental

info@billwhitleydds.com

billwhitleydds.com

1152 N. Buckner Blvd. | Suite H100A • Dallas, TX 75218

(214)320-9679

Patient Information

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) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

I prefer to be contacted by

☐ Cell Phone ☐ Text ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

_____

In an emergency, who should be notified? Please enter name, phone number and relationship below

_____

_____

Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

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

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

Birth Date: _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Patient's relationship to Responsible Party

☐ Self ☐ Spouse ☐ Child ☐ Other

Primary Dental Insurance

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

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

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

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

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Insurance Phone # _____

Insurance Authorization

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits 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.

Dental Health Information

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist Name and Phone Number

_____

_____

Approximate date of most recent dental exam and/or dental x-rays

_____

_____

I routinely see a dentist every

◯ 3 mos ◯ 4 mos ◯ 6 mos ◯ 12 mos ◯ Not routinely

What is your immediate concern about your dental health?

_____

_____

Check all that apply *

- ☐ Currently in pain/discomfort
- ☐ Complications from past dental treatment
- ☐ Trouble getting numb
- ☐ Any reactions to local anesthetic
- ☐ Had/Have braces or orthodontic treatment
- ☐ Experiences dry mouth
- ☐ Sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Popping and/or clicking of your jaw joint
- ☐ Difficulty chewing
- ☐ Clenching or grinding of teeth
- ☐ Gums bleed when brushing or flossing
- ☐ Diagnosed with and/or treated for gum disease
- ☐ Bone loss around your teeth
- ☐ Unpleasant taste or odor in your mouth
- ☐ Gum recession
- ☐ Teeth become loose on their own (without injury)
- ☐ Burning sensation in your mouth
- ☐ Snores or wakes up frequently during the night

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

Consent for Dental Services

I give consent to receive dental treatment deemed necessary by the Whitley Family Dental providers. Treatment procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam/composite fillings and crowns), periodontal gum treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries risks including, but not limited to, swelling, bruising, allergic reaction, changes in pain perception, prolonged anesthesia, and/or permanent nerve damage.

I give consent to take x-rays, study models, review photographs, or any other diagnostic aids deemed appropriate by the Whitley Family Dental providers to make a thorough diagnosis of my dental needs.

This consent shall be considered in effect until rescinded or revoked.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Consent for Financial Obligation

This agreement is to inform you of your financial obligation to our practice. All charges you incur for any treatment that is provided are your responsibility regardless of your insurance coverage. We will always recommend treatment based upon your dental needs, not based on insurance coverage which can be inadequate with some dental plans. Your estimated co-payment/deductible may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Third party extended payment financing is available upon request and approval. Returned checks and balances older than 90 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Our practice will accept an assignment of benefits from your insurance company and it is important to understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company. Although we are willing to submit dental claims on your behalf, we do not accept responsibility for the outcome of the transaction. Our practice does not guarantee that your insurance company will assist with payment for treatment you receive from our practice. If your claim is denied, you will be 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 for your use in the dispute. It is your responsibility to resolve any type of dispute over payment made or not made by your insurance company to our practice.

Cancellations and Rescheduling Dental Appointments
Our office does require 24 business hours notice to cancel/reschedule existing appointments with us. If we do not receive such notice, there will be a charge of $75.00 for any missed appointment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Signature of patient, parent, or guardian completing this form:

Signature _____ **Date** 1: _____

Relationship to patient *

☐ Patient ☐ Parent ☐ Guardian

Response Date: ___/___/_____

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Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

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.

- ☐ ADD/ADHD
- ☐ Allergy - Anesthetic
- ☐ Allergy - Metal
- ☐ Anaphylaxis
- ☐ Artific. Heart Valve
- ☐ Blood Disease
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Cortisone Medicine
- ☐ Easily Winded
- ☐ Excessive Thirst
- ☐ Frequent Diarrhea
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolaps
- ☐ Osteoporosis
- ☐ Persistent Fever
- ☐ Recent Weight Loss
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell Disease
- ☐ Spina Bifida
- ☐ Surgery
- ☐ Tobacco Use
- ☐ Tumors or Growths
- ☐ AIDS/HIV
- ☐ Allergy - Aspirin
- ☐ Allergy - Other
- ☐ Anemia
- ☐ Artificial Joint
- ☐ Blood Transfusion
- ☐ Chemical Dependency
- ☐ Cold Sores/Fever Bl.
- ☐ Depression
- ☐ Emphysema
- ☐ Fainting/Dizziness
- ☐ Frequent Headaches
- ☐ Hay Fever
- ☐ Heart Pacemaker
- ☐ Hepatitis A
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Lung Disease
- ☐ Multiple Sclerosis
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Care
- ☐ Renal Dialysis
- ☐ Scarlet Fever
- ☐ Sinus Trouble
- ☐ Stomach/Intestinal
- ☐ Swelling of Limbs
- ☐ Tonsilitis
- ☐ Ulcers
- ☐ Alcohol Addiction
- ☐ Allergy - Cephalexin
- ☐ Allergy - Penicillin
- ☐ Angina
- ☐ Aspergers
- ☐ Breathing Problems
- ☐ Chemotherapy
- ☐ Congential Heart Dis
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fosomax
- ☐ Genital Herpes
- ☐ Heart Attack
- ☐ Heart Trouble/Dis
- ☐ Hepatits B or C
- ☐ Hives or Rash
- ☐ Leukemia
- ☐ Lupus
- ☐ Naproxin
- ☐ Parathyroid Disease
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Sepsis
- ☐ Sjogren's Syndrome
- ☐ Stroke
- ☐ Taking Birth Control
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Allergy - Acrylic
- ☐ Allergy - Latex
- ☐ Alzheimer's Disease
- ☐ Arthritis/Gout
- ☐ Asthma
- ☐ Bruise Easily
- ☐ Chest Pains
- ☐ Convulsions
- ☐ Drug Addiction
- ☐ Excessive Bleeding
- ☐ Frequent Cough
- ☐ GERDS
- ☐ Heart Attack/Failure
- ☐ Hemochromotosis
- ☐ Herpes
- ☐ Hypoglycemia
- ☐ Liver Disease
- ☐ Medications
- ☐ Oral Contraceptives
- ☐ Parkinsons
- ☐ Radiation Treatments
- ☐ Rheumatism
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Surgeries
- ☐ Thyroid Disease
- ☐ Tubes in Ears
- ☐ Yellow Jaundice

- ☐ Recent Hospitalization
- ☐ Pregnant/Planning Pregnancy
- ☐ Presently being treated for any other illness
- ☐ Nursing
- ☐ Pre-medication - explain below

If any conditions or alerts selected above needs further clarification, please describe below

_____

_____

_____

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

Name of physician and date of last physical exam

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

List all medications (prescription and non-prescription), including regular dosages of aspirin. *

Please list any allergies and/or allergies to medications.

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

HIPAA Acknowledgment

I understand I can review and download/receive a copy of the Whitley Family Dental Notice of Privacy Practices found at www.billwhitleydds.com. I understand that I may inspect or copy any protected health information from my patient file. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Please list the first and last names of any person(s) we may discuss your appointment, treatment, and or financial obligations with:

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Signature of patient, parent, or guardian completing this form:

Signature _____ **Date** 1: _____

Relationship to patient:

☐ Patient ☐ Parent ☐ Guardian